



KETTLE VALLEY FAMILY DENTAL

103-5315 Main St
Kelowna, British Columbia, V1W 4V3
(778) 477-0411

PATIENT AGREEMENT

This Patient Agreement contains important information about your dental treatment at Kettle Valley Family Dental. By signing this patient agreement, you acknowledge that you have read and agree to all the terms and conditions contained herein. Please read carefully and ask questions you may have.

1. Kettle Valley Family Dental will be presenting the best dental treatment options and other options if applicable to you and/or your family and plan to treat you according to your dental and whole-body needs and requirements.
2. Kettle Valley Family Dental uses well-evaluated dental products and medications to provide you and/or your family with the dental treatment you need. All products have been studied and are known to be safe for use. This does not rule out the possibility of adverse or allergic reactions that you may have, or relevant medical health history information intentionally or unintentionally not disclosed.
3. Kettle Valley Family Dental is in no way associated or affiliated with any insurance company. This means we have no direct contact with your insurance company and have no inside information, ability, or control as to what your assistance plan will pay for benefits that are listed in your client packet. We determine treatment needed before knowing any of your insurance details.
4. Your insurance is a benefit to you and is there to assist you with the costs of dentistry. We strongly recommend that you find out what your insurance coverage is, as per your insurance contract.
5. Kettle Valley Family Dental has extended the courtesy to direct bill the insurance company on behalf of their patients. On the date of service, we will submit the claim to insurance and collect the remaining balance from the patient. Once insurance has paid a portion, it is the responsibility of the patient to pay any outstanding amount. Kettle Valley Family Dental takes no responsibility in what the insurance deems to pay for the service provided.

I HAVE READ THIS PATIENT AGREEMENT, FULLY UNDERSTAND, AND AGREE TO ALL ITS TERMS AND CONDITIONS.

Name: _____ Signature: _____ Date: _____