BRISTOL PARK DENTAL

6 Park Place, Bristol, VT 05443 | 802.453.7700 | info@bristolparkdental.com

Medicaid Consent to Treatment
Acknowledgement of Financial Responsibility of Patient

The undersigned patient, or individual acting on behalf of the patient, agrees as follows:

Authority is granted by undersigned to Bristol Park Dental to render treatment of the patient.

I authorize Bristol Park Dental to release any information required for payment of insurance claims.

I authorize my insurance benefits to be paid directly to Bristol Park Dental, realizing that I am responsible to pay for any non-covered services.

I understand that I am responsible for all charges incurred through Bristol Park Dental. Payment or estimated co-payment is expected at the time of the undersigned patient visit. Payment arrangements can also be made by applying for a line of credit through Care Credit. (The office can assist with the application process.)

This authorization will remain in effect until terminated by you, your personal representative, or another individual(s) of legal entity authorized to do so by court order or law.

Accounts not paid in full after 90 days will be sent to a collection agency. The patient, patient's responsible party, or legal guardian will pay any collection fees associated with the collection process. You may also be responsible for up to 12% in annual interest. If your check is returned, your account will be charged a returned check fee of $30. If you choose to pay on your Care Credit card for services and a return takes place, we follow the guidelines set out by Care Credit and the refund will be placed on the Care Credit card. If the refund is less than the amount of services, please remember your original payment terms do not change.

I understand that the Adult Program is limited to $1,000 per individual per calendar year (annual cap). If an individual reaches their 21st birthday and has received dental care during the course of the year, the dental benefit already paid will be applied to the annual $1,000 adult maximum benefit. The benefit is considered exhausted if the total reimbursement is greater than or equal to $1,000, and will not begin again until the start of the new calendar year.

I acknowledge Bristol Park Dental may bill me for services that exceed my annual capped amount, but not more than the appropriate procedure code rate in the Vermont Medicaid Dental Procedure Fee Schedule, if it is a Vermont Medicaid covered service. I hereby acknowledge there are dental services that are Non-Covered by Vermont Medicaid and subject to Usual & Customary charges.

I authorize Bristol Park Dental to contact me with appointment reminders using the personal information I have provided. This includes phone calls, texts, and/or emails. I authorize my immediate family including spouse and/or dependents to schedule and/or confirm appointment(s) dates and times.

Cancellation Policy: In instances of repeated non-compliance with scheduled visits, we also reserve the right to limit care to a same day or space available basis, or require a pre-payment. Failure to show up to any scheduled visits will result in our practice dismissing you as a patient.

Print Name: ____ Date of Birth: ________________

Patient/Guardian Signature: ____ Date: _________________

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Medicaid Provider ID: 6702255

SERVICES NOT COVERED BY ADULT MEDICAID PROGRAM

D0340 Cephalometric radiographic image - $70
D0350 Oral/Facial Photographic Image obtained intraorally or extraorally - $32
D0391 Interpretation of Diagnostic Image by a Practitioner Not Associated with Capture of the Image, Including the Report - $35
D1330 Oral Hygiene Instructions - $21
D1351 Sealant – Per Tooth - $35
D1352 Preventive resin restoration in a moderate to high caries risk patient – permanent tooth - $70
D1516 Space Maintainer – Fixed – Bilateral, maxillary - $250
D1517 Space Maintainer – Fixed – Bilateral, mandibular - $250
D1526 Space Maintainer – Removable – Bilateral, maxillary 225 - $225
D1527 Space Maintainer – Removable – Bilateral, mandibular - $225
D1551 Re-Cement or Re-Bond Bilateral Space Maintainer – maxillary – effective 1/1/2020 - $50
D1552 Re-Cement or Re-Bond Bilateral Space Maintainer – mandibular – effective 1/1/2020 - $50
D1553 Re-Cement or Re-Bond Bilateral Space Maintainer – Per Quadrant – effective 1/1/2020 - $50
D1575 Distal Shoe Space Maintainer – Fixed – Unilateral Per Quadrant - revised 1/1/2020 (per quadrant added) - $190
D2720 Crown – Resin to High Noble Metal - $600
D2740 Crown – Porcelain/Ceramic substrate - $600
D2750 Crown – Porcelain to High Noble - $600

D2751 Crown – Porcelain to Base Metal - $600
D2752 Crown – Porcelain to Noble Metal - $600
D2753 Crown – Porcelain Fused to Titanium and Titanium Alloys – effective 1/1/2020 D2790 Crown – Full Cast High Noble Metal - $600
D2791 Crown – Full Cast Base Metal - $407
D2792 Crown – Full Cast Noble Metal - $600
D2952 Post and Core in addition to crown, indirectly fabricated - $307
D2960 Labial Veneer – Laminate - $220
D2980 Crown Repair, by report - $110
D3120 Pulp Cap (Indirect; ex Final Restoration) - $71.00
D3351 Apexification/Recalcification – Initial Visit - $284
D3352 Apexification/Recalcification – Interim Medication Placement - $300
D3353 Apexification/Recalcification – Final Visit - $169
D3450 Root Amputation – Per Root - $181
D3910 Surgical Procedure for Isolation of Tooth with Rubber Dam - $71
D3920 Hemisection (Including any Root Removal. Not Including Root Canal Therapy) - $181
D4210 Gingivectomy or Gingivoplasty, Four or more contiguous teeth or bounded teeth spaces per quadrant - $273
D4211 Gingivectomy or Gingivoplasty, One to three contiguous teeth or bounded teeth spaces, per quadrant - $130
D4212 Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure per Tooth - $48
D4240 Gingival Flap Procedure, Including Root Planning – Four or more contiguous teeth or bounded teeth spaces per quadrant - $308
D4241 Gingival Flap Procedure, Including Root Planing – One to three contiguous teeth or bounded teeth spaces, per quadrant - $150
D4249 Clinical Crown Lengthening-Hard Tissue - $400

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D4260 Osseous Surgery (including elevation of a full thickness flap entry and closure) - four or more teeth per quadrant - $600
D4261 Osseous Surgery (including elevation of a full thickness flap entry and closure) - one to three teeth per quadrant 300 N 4 procedures per lifetime - $300
D4263 Bone replacement graft- retained natural tooth - $373
D4270 Pedicle Soft Tissue Graft Procedure - $338
D4277 Free Soft Tissue Graft Procedure - $373
D4278 Free Soft Tissue Graft Procedure - $373
D5110 Complete Denture – Maxillary - $850
D5120 Complete Denture – Mandibular - $850
D5130 Immediate Denture – Maxillary - $875
D5211 Maxillary Partial Denture – Resin Base - $575
D5212 Mandibular Partial Denture – Resin Base - $575
D5213 Maxillary Partial Denture – Cast Framework - $900
D5214 Mandibular Partial Denture – Cast Framework - $900
D5225 Maxillary Partial Denture – Flexible Base - $775
D5226 Mandibular Partial Denture – Flexible Base - $775
D5511 Repair Broken Complete Denture Base – Mandibular - $100
D5512 Repair Broken Complete Denture Base - Maxillary - $100
D5520 Repair Missing or Broken Teeth – Complete Denture - $82
D5611 Repair Resin Denture Base – Mandibular - $91
D5612 Repair Resin Denture Base – Maxillary - $91
D5621 Repair Cast Framework, Partial Mandibular - $117
D5622 Repair Cast Framework, Partial Maxillary - $117
D5630 Repair or Replace Broken Clasp – Partial Denture - $150
D5640 Replace Broken Teeth on Existing Partial – Per Tooth - $83
D5650 Add Tooth to Existing Partial Denture - $100
D5660 Add Clasp to Existing Partial Denture - $116
D5710 Rebase Complete Maxillary Denture (Laboratory) - $250
D5711 Rebase Complete Mandibular Denture (Laboratory) - $250
D5720 Rebase Maxillary Partial Denture (Laboratory) - $250
D5721 Rebase Mandibular Partial Denture (Laboratory) - $250
D5750 Reline Complete Maxillary Denture (Laboratory) - $212
D5751 Reline Complete Mandibular Denture (Laboratory) - $212
D5760 Reline Maxillary Partial Denture (Laboratory) - $212
D5761 Reline Mandibular Partial Denture (Laboratory) - $212
D5820 Interim partial denture (maxillary) - $250
D5821 Interim partial denture (mandibular) - $250
D5863 Overdenture – Complete Maxillary - $850
D5864 Overdenture – Partial Maxillary - $575
D5865 Overdenture – Complete Mandibular - $850
D5866 Overdenture – Partial Mandibular - $575
D6010 Surg Place of Implant Body – Endo Implant $2363
D6210 Pontic – Cast High Noble Metal - $600

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D6211 Pontic – Cast Base Metal - $402
D6212 Pontic – Cast Noble Metal - $600
D6240 Pontic – Porcelain Fused to High Noble Metal - $600
D6241 Pontic – Porcelain Fused to Base Metal - $406
D6242 Pontic – Porcelain Fused to Noble Metal - $600
D6243 Pontic – Porcelain Fused to Titanium and Titanium Alloys – effective 1/1/2020 - $600
D6545 Cast Metal Retainer for Acid Etched Bridge - $357
D6750 Crown – Porcelain Fused to High Noble Metal - $600
D6751 Crown – Porcelain Fused to Base Metal - $423
D6752 Crown – Porcelain Fused to Noble Metal - $600
D6753 Retainer Crown - Porcelain Fused to Titanium and Titanium Alloys – effective 1/1/2020 - $600
D6790 Crown – Full Cast High Noble Metal - $600
D6791 Crown – Full Cast Base Metal D6792 Crown – Full Cast Noble Metal - $418

D6980 Bridge Repair, by report - $220
D7280 Exposure of an Unerupted Tooth - $300
D7282 Mobilization of Erupted or Mal-positioned Tooth to Aid Eruption to move/luxate teeth to eliminate ankylosis - $155
D7283 Placement of Device to Facilitate Eruption of Impacted Tooth - $100
D7960 Frenectomy (Frenectomy or Frenotomy) - $150
D7971 Excision of Peri-coronal Gingiva - $75
ALL ORTHODONIC SERVICES ARE NOT COVERED UNDER THE ADULT MEDICAID PROGRAM
D9950 Occlusal Analysis – Mounted Case - $240
D9951 Occlusal Adjustment – Limited - $70
D9952 Occlusal Adjustment – Complete - $260
D9973 External Bleaching – Per Tooth - $116
D9974 Internal Bleaching – Per Tooth - $116

**Other codes may not be included on the above list. Please speak with your provider/Front Desk staff regarding non-covered codes and their cost.

Print Name: ____ Date of Birth: __________________

Patient/Guardian Signature: ____ Date: _________________