Planned Financial Informed Consent

Patient name: _____ **Dentist office:** _____

Member name: _____ **Dentist office number:** _____

Member ID number: _____

	Covered Benefit			Elective / Optional Treatment			Patient Financial Responsibility		
Tooth Number	ADA Proc Code[1]	Description of Service	Dentist Fee	ADA Proc Code[1]	Description of Service	Dentist Fee	Patient Copay for Covered Benefit Procedure	Upgrade Cost	Total Patient Financial Responsibility
									0
									0
									0
									0
									0
									0
						Total	0	0	0

I have been given the option of selecting an enhanced, upgraded and/or non-covered dental service. I have asked my dentist to perform the elective service(s) as shown above. I acknowledge all of the following:

a) The elective/optional (e.g. enhanced, upgraded or non-covered) service(s) listed above, including all associated patient costs, have been fully explained to me;
b) Aetna does not cover the elective/optional services; and
c) I am financially responsible for the associated costs as shown above.

Patient signature: _____ **Date:** _____

(Parent or guardian if patient is a minor.)

Dentist signature: _____ **Date:** _____

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