Informed Consent for Alternate Treatment

Patient Name	Member ID	Patient Address/Phone number
Date of Birth	**Plan Name/Number**	

Tooth/ Area	Covered Services					Alternative Treatment*					Patient's out of pocket for elected services	Patient's Acceptance (Please initial)
	CDT Code	Procedure Description	Copayment	Accept	Decline	CDT Code	Procedure Description	Alternative Cost*	Accept	Decline		

**"Alternative Treatment" means another service offered to the member that is not a covered service or is an upgrade to a covered service. Covered service(s) is a benefit that your dental plan will pay for, at no cost to the member. Alternative Treatment is not covered by your plan. If you chose the Alternative Treatment, you would have to pay for the non-covered service. You can choose between the covered service(s) and Alternative Treatment. The formula for Alternative Cost (cost you pay) = usual cost of Alternative Treatment minus (-) the usual cost of the covered service plus (+) any listed copayment for the covered service."*

Total patient responsibility for Alternative Treatment: $ _____

By signing below **(Dentist),** I confirm that I have explained to the patient: his/her treatment options, the risks and benefits of the Alternative Treatment, the cost of Alternative Treatment, and other covered services that would meet the dental standards of care.

By signing below **(Patient),** I understand and agree to the following:

1. The dentist has explained and answered my questions related to covered service(s), alternative treatment options, and the cost of non-covered treatment.
2. I understand that I have the right to choose from covered service(s) or the alternative treatment written above.
3. I have chosen and consented to the Alternative Treatment written above.
4. I understand I am responsible for the cost of the Alternative Treatment, and that the Plan will not cover the cost of the Alternative Treatment.
5. I have selected **not** to use covered service(s) that are within dental standards of care.
6. I understand that there may be financing options available, and it is my own discretion should I elect to use a finance company. I do not have to select a financing option or use one.

If I have any questions or concerns about my dental treatment plan, copayments, or additional costs, I will contact LIBERTY Dental Plan at **800-268-9012** before signing below.

Patient Name	Patient Signature (Parent or Guardian)	Dentist Name/Signature	Date