Consent for Non-Covered Treatment

Member	
Member Name:	**ID #:**
Patient Name:	**DOB:**
Address:	**Phone:**
City, State, Zip:	

I understand that the dental services listed below are non-covered services under my dental plan. LIBERTY Dental Plan does not cover these services because:

- They are not listed as covered benefits on my dental plan.
- They are not payable under my dental plan, due to benefit limitation.

As shown by my initial below, I am choosing to get these non-covered services at the agreed upon price. My initials and signature show that I understand this financial charge. I will pay the dentist when I receive his/her billing statement.

Treatment

CDT Code	Treatment Description	Cost	Patient initial for each elected code.

Dentist Signature: _____ **Date:** _____

Member Signature: _____ **Date:** _____

This signed form is required to be kept as part of the member's dental chart.