

Patient Signature (Parent or Guardian)

LIBERTY Dental Plan Informed Consent for Alternative Treatment

Patient Name Subscriber (if different than Patient)							Member ID Plan Number						
Tooth/ Area	Covered Services					Alternative Treatment*				Patient's	Patient's		
	CDT Code	Procedure Description	Copayment	Accept	Decline	CDT Code	Procedure Description	Alternative Cost*	Accept	Decline	Responsibility for Procedure Elected	-	
covered b between	y your plan w the two servio	hereas the Alternative Treatment is not co	overed by your plan ed "Patient's Respo	(mea	ning t	hat if you el	led for the same tooth or condition(s) as the contect the Alternative Treatment, you will incur the Elected." Formula for Alternative Cost = usua	e "Alternative Cost"	spec	ified).	. You have the o	ption to choose	
							Total patient responsibility f	or procedure(s) el	ecte	ed: \$		
covered	under his/he	the patient: his/her treatment option or benefit plan would nonetheless also No				•	natives to) each, and that although Alteri care.	native Treatment	is b	eing	proposed that	those services	
Dentist Signature De						Dentis	tist Name				Da	ate	
additiona understa cost of th	al costs assoond the risks, ne Alternativ	ciated with such treatment ("Alternat benefits and costs of each; (iii) if I ha re Treatment, that such treatment is r	ive Costs"); (ii) I u ive elected any Alt not covered by LIB	nders terna SERTY	stand tive 1 ' Den	that I hav Treatment tal Plan, ar	he proposed alternative or upgraded treat e the right to choose either the Covered Se specified above, I consent to such treatme d that the Covered Service(s) I am declining gation to select a specific financing option	ervice or the Alte ent and I understang mg would have als	rnativ and: t so me	ve Tre hat I et the	eatment outline am solely respo e relevant denta	ed above and onsible for the al standards of	

Patient Name

Date