**WESTEND SMILES FAMILY DENTAL CARE**

**TERMS AND CONDITIONS FOR PATIENTS COVERED UNDER**

**THE CANADIAN DENTAL CARE PLAN (CDCP)**

**CONFIRMATION OF COVERAGE**

The patient/guardian confirms that they are lawfully currently covered under the Canadian Dental Care Plan (CDCP). The patient understand that their coverage will be based on their percentage of eligible services costs covered by the CDCP, as determined by their family net income. The patient/guardian understands that it is their responsibility to inform the clinic of any changes to their coverage or eligibility in a timely manner, failure to do so could result in unexpected out-of-pocket expenses for services not covered by the CDCP.

**TREATMENT RECOMMENDATIONS**

The clinic will always base its treatment recommendations on what is best for the patient's oral health, regardless of whether it is covered by the CDCP or any other plan. The clinic will not compromise on the quality of care provided solely to accommodate dental coverage limitations.

**TRANSPARENCY OF COVERAGE**

The clinic will discuss with the patient/guardian which of the recommended services will and will not be covered by the CDCP and what, if any, amounts will be charged to the patient/guardian before they agree to care.

**FEE STRUCTURE AND CO-PAYMENT TERMS**

The clinic's fees will be based on the Ontario Dental Association (ODA) Fee Grid. The patient will be responsible for any co-payment. The co-payment will be due and in full on the day of service.

**The co-payment includes:**

1. The portion of the clinics fee not covered by the CDCP (the difference between the CDCP Fee and the ODA fee), AND
2. The percentage of the eligible service fee not covered under the CDCP based on the patients family net income

**CLAIMS SUBMISSION**
The clinic will submit claims for direct payment for services covered under the CDCP for the patient. The patient cannot submit a claim for reimbursement to the CDCP.

**CONFIDENTIALITY**

The Clinic will maintain confidentiality regarding all personal and financial information related to the patient's CDCP coverage. The patient is aware that as part of the CDCP application process they gave consent that their personal information may be shared when considered useful by Sun Life in the context of the program administration, conducting claims verification and managing claims. This information may include but is not limited to details on the services provided, patient clinical data, payments and x-rays.

**GOVERNING LAW**

This Agreement shall be governed by and construed in accordance with the laws of Ontario.

**WESTEND SMILES FAMILY DENTAL CARE**

**CONSENT FORM FOR PATIENTS COVERED UNDER**

**THE CANADIAN DENTAL CARE PLAN (CDCP)**

\*Name of the Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge that I am a patient or guardian of a patient at WEST END SMILES FAMILY DENTAL CARE and who has the Canadian Dental Care Plan (CDCP) insurance coverage. I understand and agree that WEST END SMILES FAMILY DENTAL CARE charges in accordance with the current year Ontario Dental Association fee guide prices for the services provided. I further acknowledge that any difference between the fee charged, and the amount covered by CDCP insurance plan is my responsibility for payment on the day services are rendered.

By signing below, you acknowledge that you have read, understood, and agreed to the terms and conditions of this Agreement.

**PATIENT/GUARDIAN SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE:** \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ (YYYY/MM/DD)