## 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. |
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**Dentist Signature:** _____ **Date:** _____

**Member Signature:** _____ **Date:** _____

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