LIBERTY Dental Plan
Informed Consent for Alternative Treatment

Patient Name	Member ID
Subscriber (if different than Patient)	**Plan Number**

Description of Alternative services and reason for recommendation:

Tooth/ Area	Covered Services					Alternative Treatment*					Patient's Responsibility for Procedure Elected	Patient's Acceptance (Please initial)
	CDT Code	Procedure Description	Copayment	Accept	Decline	CDT Code	Procedure Description	Alternative Cost*	Accept	Decline		

*****"Alternative Treatment" means an alternative or upgrade treatment that has been proposed or recommended for the same tooth or condition(s) as the corresponding "Covered Service." The Covered Service is listed as covered by your plan whereas the Alternative Treatment is not covered by your plan (meaning that if you elect the Alternative Treatment, you will incur the "Alternative Cost" specified). You have the option to choose between the two services and will be responsible for the specified "Patient's Responsibility for Procedure Elected." Formula for Alternative Cost = 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 procedure(s) elected: $ _____

I have explained to the patient: his/her treatment options, the risks and benefits of (and alternatives to) each, and that although Alternative Treatment is being proposed that those services covered under his/her benefit plan would nonetheless also meet the relevant dental standards of care.

☐ Yes ☐ No

Dentist Signature Dentist Name Date

By signing below, I acknowledge the following: (i) the dentist named above has explained to me the proposed alternative or upgraded treatment specified above ("Alternative Treatment") and the additional costs associated with such treatment ("Alternative Costs"); (ii) I understand that I have the right to choose either the Covered Service or the Alternative Treatment outlined above and I understand the risks, benefits and costs of each; (iii) if I have elected any Alternative Treatment specified above, I consent to such treatment and I understand: that I am solely responsible for the cost of the Alternative Treatment, that such treatment is not covered by LIBERTY Dental Plan, and that the Covered Service(s) I am declining would have also met the relevant dental standards of care; (iv) I understand that while there may be financing options available, I am under no obligation to select a specific financing option or to use one at all; and (v) if I have any questions or concerns about my dental treatment plan, copayments or additional costs, I will have contacted LIBERTY Dental Plan at 800-268-9012 or 888-700-0643 (Nevada) before signing below.

Patient Signature (Parent or Guardian) Patient Name Date