**Consent for Non-covered Services**

I realize that I am responsible for additional fees that are associated with the following services or any other services that are not covered under my dental insurance plan:

1. White Posterior fillings (Back Teeth)
2. Semi-precious metal on all crowns and bridges/lab fee
3. Procera Crowns
4. Core Buildups
5. Fluoride Treatments
6. Lab Dees (dentures, partials, night guards and flippers)
7. Limited Exams
8. Implant Crowns and Abutements

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Print Signature Date