OUTCOME ASSESSMENT/PATIENT ACCOUNT ADJUSTMENT FORM

TO BE COMPLETED FOR RE-TREATMENT (AT NO ADDITIONAL FEE TO THE PATIENT) OR REFUND FOR TREATMENT COMPLETED.

Patient's Name: _____ Date: _____

Densyst #: _____ GP: _____

Current Provider Name: _____ Current Provider No.: _____

Original Provider Number: _____ Date of Original Treatment: _____

Provider Numbers of all faculty supervising original treatment: _____

Description of original treatment:

_____

_____

Reason for considering re-treatment/refund/adjustment:

_____

_____

_____

_____

Signature of Supervising Faculty

Recommended Action:

_____

_____

_____

_____

***Authorizing Signature/Date**

***ALL PROSTHODONTIC AND ENDODONTIC PROCEDURES REQUIRE SIGNATURE OF DEPARTMENT CHAIRPERSON, MANAGER OR FISCAL AFFAIRS PERSONNEL SIGNATURE FOR ALL OTHER PROCEDURES.**

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ADJUSTMENT

Amount to Write-off: $_____

Signature of Patient Care Coordinator: _____

ACTION TAKEN: _____

_____

_____

Financial impact (re-treatment only) _____

PROCESSOR'S SIGNATURE: _____