CONSENT FOR SERVICES

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to my doctor's use and disclosure of my (or my child's) records to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records (or my child's) records to the following persons who are involved in my care (or my child's) care or payment for that care. My consent to disclosure of records shall be effective until I revoke it in writing.

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Spouse or other guardian

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends on reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services performed without previous financial arrangements must be paid for in cash at the time they are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is ultimately responsible for payments. This office will submit claims to insurance companies as a service to our patients and accept payment as a credit to your patient's accounts. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services, and that I am financially responsible for all accounts. A service charge of 1.5% per month (18% annually) on the unpaid balance will be charged on all accounts exceeding 60 days.

I, the undersigned, understand that the fee estimated for my dental care can only be extended for 6 months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to Doctor, or his assignee, at the time services are rendered, or within 5 days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected by me in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit is instituted hereunder.

I grant my permission to you or your assignee to telephone me at home or work to discuss matters related to this form. And lastly, I am aware of the cancellation policy in which that failure to show for my appointment, or to cancel at least 48 hours prior to appointment time, may result in a $50.00 charge.

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT AND AGREE TO THEIR CONTENT

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Patient or Guardian Date