Consent for Treatment and Services

As a condition of your treatment by this office, financial arrangements must be made in advance, and financial responsibility on the part of each patient must be determined prior to treatment. All emergency dental services, or any dental services performed without prior financial arrangements, must be paid for in cash at the time of services are performed.

If you carry dental benefits understand that all dental services provided are charged directly to you and that you are personally responsible for payment, whether or not your insurance disperses benefits. This office will help you prepare the benefit forms or assist in making collections from your insurance company and will credit any such benefits to your account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. By signing at the bottom of this page, I authorize the use of my signature on all benefit claim submissions.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

As a courtesy, our office will either send you and email and/or call to remind you of your appointment 48 hours in advance. A 48 hour notice during office hours is requested for the cancellation and/or rescheduling of an appointment. Our message system does not accept cancellations or rescheduling requests. Appointments cancelled or rescheduled with less than a 48 hour notice will incur a penalty charge of $75.00. We understand that emergencies may arise that will result in cancellation, and we are always willing to reschedule appointments under these circumstances without a fee being charged.

I understand that the estimated fee for the diagnosed dental care can only be extended for a period of six months from the examination date.

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 said doctor, or his assignee, at the time said services are rendered, or within five (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 to, 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 be instituted hereunder.

I have read the above conditions of treatment and payment and agree to their content. I grant my permission to your or your assignee to telephone me at home or at my office to discuss matters related to this form.

_____ Date:_____

SIGNATURE OF PATIENT, PARENT AND/OR GURDIAN

Relationship to Patient:_____

We ask that you allow us to keep a credit card on file. With your approval, we will charge your credit card for any unpaid balance on treatment completed in this office. Your signature below authorizes our office to charge your credit card.

Credit Card: ☐ Visa ☐ M/C ☐ Discover ☐ American Express

Card No.:_____ Exp. Date:_____

_____ Date:_____

SIGNATURE OF PATIENT, PARENT AND/OR GURDIAN

Relationship to Patient:_____