CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon 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, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services 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 personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Your Insurance Company may determine that the procedures or services provide for you by this office are not deemed dentally necessary or are non-covered services. It is possible that your insurance may deny payment based on any of the following:

The procedure is considered a **cosmetic service.**

The procedure is a **non-covered service** under your dental plan.

We are **not** a contracted provider with your insurance carrier.

You did **not** obtain a required referral from your insurance carrier.

If your insurance carrier denies payment for the services provided by this office for any of the reasons stated above, you agree to be personally and fully responsible for payment.

A service charge of 1½ per month (18% per annum) on the unpaid balance will be charged on all +9accounts exceeding 90 days, unless previously written financial arrangements are satisfied. Accounts not settled within 90 days will be sent to collection with a charge equal to 35% of the balance being added to the account to recover legal fees and collection costs.

I understand that the fees estimate listed for this dental care can only be extended for a period of six 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 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 value of said services shall be as billed. 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 were instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

PLEASE NOTE: A 24-HOUR NOTICE IS REQUIRED FOR ALL MISSED APPOINTMENTS. OUR OFFICE POLICY IS $75.00 FOR EVERY SCHEDULED HOUR MISSED. NO EXCEPTIONS.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party