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 full at the time services are performed.

Patients who have a dental insurance plan, understand that **all dental services furnished are charged directly to the patient and the patient or responsible party is personally responsible for payment of all dental services.** This office will prepare patient insurance forms and 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.

I understand that the treatment investment and the fee listed for this dental care can only be extended for a period of 90 days from the date of the patient planning appointment. If the patient doesn't have a planning appointment, this courtesy will be extended for the same 90 day period from the date of the initial exam.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the Doctors reasonable fee of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable fee 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 grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I authorize this office to use my name (in complete or edited form), photograph(s), or other images as may be necessary of me (i.e. radiographs and digital photos), with or without my given name and city for advertising, education or any other lawful purpose and I release and forever discharge said Doctor from any claim, demands or liability on account of such use or for the quality of the reproduction of the photograph or photocopy provided.

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

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Patient, Parent or Guardian Signature Date

_____ _____

Patient Name (Please Print) Additional Patient Names (if minors)