Consent for Service

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from its patients for the costs incurred 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 at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient. Our office will file with the insurance company as a courtesy and the patient is responsible for the estimated portion not covered by the insurance company on the date of service. However, any services that are not paid by the insurance company will be the patient's responsibility.

A service charge will be applied per month on the unpaid balance on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

A service charge of $20.00 will be charged to each patient that does not attend their appointment or call the office within 24 hours to cancel or reschedule.

I understand that the fee estimated for my dental care can only be extended for a period of six (6) months from the date of the examination.

In consideration for the professional services rendered to my, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to the Doctor, or his assignee, at the time said services are rendered or within five days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be 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 term or condition and I further agree to pay all costs and reasonable attorney fees if suit be initiated.

I great my permission to you, the practice employees and/or agents to contact me at home, my work or/and all phone numbers, to discuss matters related to this form, for the purpose of treatment and insurance of payment.

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND, BY SIGNING BELOW, AGREE TO THEIR CONSENT.

NAME: _____ DATE:_____

Acknowledgement of Receipt of Notice of Privacy Practices.
I have received a copy of this office's Notice of Privacy Practices.

NAME: _____ DATE:_____

We attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices and acknowledgement could not be obtained because:

__ Individual refused to sign
__ Communication barriers prohibited obtaining the acknowledgement.
__ other