

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments, and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures, and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures, and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage benefit that I may have is based on a contract between my insurance company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance information and any changes thereto.

All returned checks will be subject to a \$75 returned check fee. Any account balances that remain unpaid for 30 days from the date of service shall accrue interest at the rate of 24% per year and may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection costs of \$25. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company and any agent thereof. I hereby assign to the dentist all of the insurance due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email, or phone number (whether a cell phone or landline) at and facsimile number, email address, or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient Signature \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Guardian/Responsible Party, if minor \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

