Consent for Treatment / Financial Agreement

I. We prefer that you pay your estimated portion after insurance at each visit. For patients without insurance we offer a 5% discount off of your total treatment (minus any lab charges) for payment at the time of service. You may also pay your balance in 3 equal payments with a credit card on file. Interest will be charged on all account balances over 90 days.

II. We accept VISA, MasterCard, Discover and American Express.

III. If you have dental insurance your insurance contract is between the patient and the insurance company. The patient is responsible for all account balances, even with insurance benefits. We will bill your insurance company as a courtesy to you, but we cannot guarantee your benefits. Any oral or written representation we make in good faith to you concerning your benefits is not binding on us and will not in any way or for any reason be considered a modification of this writing.

IV. We also have information regarding an outside finance company that works with our office. Please contact the front office with inquiries.

V. The age majority in the state is 18 years old. The parent that brings in the minor child is responsible for payment.

VI. Past due accounts will be sent to a collection agency at our discretion. We charge $25.00 for returned checks. Broken appointments are charged $75.00 per missed hour of time if at least 2 business days notice is not given.

VII. I understand that I am responsible for the entire balance of the account regardless of insurance coverage and that this office is extending credit to me.

I AUTHORIZE INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE DOCTOR PROVIDING DENTAL CARE. I ALSO GIVE PERMISSION FOR THE DOCTOR TO RELEASE INFORMATION IN ORDER TO PROCESS THE CLAIM.

I HEREBY AUTHORIZE MY DOCTOR'S OFFICE TO ADMINISTER SUCH MEDICATIONS AND PERFORM SUCH DIAGNOSTIC AND THERAPEUTIC PROCEDURES AS MAY BE NECESSARY FOR PROPER MEDICAL CARE.

IF THE TREATMENT IS FOR A MINOR CHILD, I, THE PARENT OR LEGAL GUARDIAN OF MY CHILD, AUTHORIZE AND CONSENT TO ROUTINE AND EMERGENCY DENTAL TREATMENT FOR MY CHILD WHEN DEEMED NECESSARY BY A LICENSED DENTAL PROVIDER. I UNDERSTAND THAT IF THE TREATMENT NEEDS OF MY CHILD CHANGE THEN THE NEEDED TREATMENT WILL BE COMPLETED AND I AM RESPONSIBLE FOR ANY ADDITIONAL COSTS INVOLVED. IN THE EVENT OF A MEDICAL EMERGENCY, AND I CANNOT BE REACHED, I, THE PARENT OR LEGAL GUARDIAN OF MY MINOR CHILD, AUTHORIZE A LICENSED DENTAL PROVIDER TO PROVIDE EMERGENCY MEDICAL TREATMENT AND USE HIS OR HER DISCRETION IN AUTHORIZING ANY MEDICAL DECISIONS FOR MY MINOR CHILD.

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS CORRECT AND I HAVE READ AND WILL SUBSCRIBE TO THE CREDIT POLICY AS PRINTED.

Printed Name of Patient: _____

Signature of Patient, Parent or Legal Guardian: _____

Relationship to patient: _____

Date: _____