CONSENT FOR SERVICES

I hereby authorize payment of the dental benefits otherwise payable to me directly to the dentist or practice. To the extent permitted under applicable law, I authorize release of any information in relation to this claim.

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

This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this office cannot render services on the assumption that our charges will be paid by an insurance company.

Accounts that are not paid within 60 days will incur late fees of $30.00 per month that balance is not paid, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within (5) days of billing if credit is extended. I further agree that the charges for the services shall be billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breech 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 to discuss this statement or my treatment.

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

Signature ____ Date ________________________
(Patient, Parent or Guardian)

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