CONSENT FOR SERVICES

FINANCIAL POLICY

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.

- **Payment is due at the time of service.**
- **We do accept VISA/MASTERCARD**
- **We offer extended payment plans with prior credit approval**

REGARDING INSURANCE

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient's account and that he or she is personally responsible for payment of all dental services not covered by the insurance company. This office will help prepare the patients insurance form or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Patients are required to pay their estimated portion of services rendered at the time of service.

FEES

A service charge of 18% per month on the unpaid balance will be charged on all accounts exceeding 90 days.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examinations.

MISSED APPOINTMENTS

Unless canceled at least 24 hours in advance, our policy is to charge for a missed appointment at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value 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 o 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 have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

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