Patient Financial Agreement and Disclosure

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by this 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 using such diagnostic methods.

I understand 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 service, treatments, procedures and/or diagnostic methods performed and utilized by the Dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or 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 or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails 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 or managed care information and any changes thereto.

All returned checks will be subject to a $ 35.00 returned check fee. Any account balances that remain unpaid for 60 days from the date of service shall accrue interest at 24% per year along with a late fee of $25.00 and may be referred to a collection company or attorney. In the event this occurs, I understand I will be liable for collections costs of $25.00. Further, in the event of 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 for the Dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the Dentist all of insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and/or managed care company to make payment directly to the Dentist for the cost associated therewith.

I further content 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 I provide to the dental office and/or by facsimile, email, or phone number (whether cell phone or landline) at any facsimile number, email address or phone number (whether cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient: _____

Date: _____

Print Name: _____

Guardian/Responsible Party, if minor: _____

Date: _____