Financial Consent

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; 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 for in full at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms 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.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for my dental care can only be extended for a period of three months from the date of the treatment plan.

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 his assignee, at the time said service are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said service 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 or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my person to you or your assignee, to telephone me at my home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content. I realize this form is in effect until revoked or rescinded, and applies to my dependent children as well.

_____ _____

Signature of patient, parent or guardian Date