PATIENT CONSENT/ PAYMENT

CONSENT:

I HEREBY AUTHORIZE AND REQUEST THE PERFORMANCE OF DENTAL SERVICES FOR MYSELF, AND I ALSO GIVE MY CONSENT TO ANY ADVISABLE AND NECESSARY DENTAL PROCEDURES, MEDICATIONS, OR ANESTHETICS TO BE ADMINISTERED BY THE ATTENDING DENTIST OR BY HER STAFF FOR DIAGNOSTIC PURPOSES OF DENTAL TREATMENT. _____ Initial

METHOD OF PAYMENT:

I UNDERSTAND AND ACKOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES AND ALL APPLICABLE CO-PAYMENTS THAT ARE RENDERED. I ALSO ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ANY FEES INCURRED IN COLLECTING ANY UNPAID DEBT, ***ALSO THAT THERE WILL BE A $25 SERVICE CHARGE ON ALL APPOINTMENTS THAT ARE MISSED WITHOUT GIVING 24 HOUR NOTICE.*** _____ Initial

I UNDERSTAND THAT I AM ALSO RESPONSIBLE FOR THE BALANCE THAT INCURS AFTER ALL CASH AND INSURANCE PAYMENTS ARE APPLIED TO MY ACCOUNT. _____ Initial

PAYMENT OPTIONS:

- ☐ CASH
- ☐ CHECK
- ☐ VISA/MASTERCARD
- ☐ MEDICAID

➢ _____

SIGNATURE OF RESPONSIBLE PARTY