Polices for Financial Responsibility and Release of Records

I understand that I am responsible for all charges whether or not they are covered by insurance. Payment must be made in full the day of the appointment for charges not covered by insurance. If there is insurance to be submitted, the percentage of the patient's responsibility will be collected at the time of the appointment. If the account is unpaid by insurance in 60 days, I understand that I am responsible for the balance in full. A refund will be issued if/when the insurance payment is received: refunds are processed on the 15th of every month. A finance charge will be added to any unpaid balance over 60 days. A late charge will also be added to any delinquent accounts.

I hereby assign to the doctor all insurance payments for services rendered. I hereby authorize and consent to the release, faxing and disclosure of dental/medical information to any applicable physicians, attorneys, and insurance companies. This consent and authorization includes all records, reports, x-rays and records of fees and charges for treatment.

I recognize that information disclosed may contain information that is protected by federal or state law and I specifically consent to disclosure of such information.

_____ _____

Signature of Responsible Party Date

CONSENT FOR TREATMENT

I hereby authorize the kind and careful practice to administer any treatment and to administer such x-rays, anesthetics, and to perform such dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition. I authorize release of any information relating to this claim. I realize that I am ultimately responsible for all cost of treatment. I understand the use of anesthetic agents embodies a certain risk. I hereby authorize my insurance benefits to be paid directly to the kind and careful practice and / or my provider of record.

Date _____

Signature (Patient or parent, for minor) _____