Consent:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient)____ and further authorize and consent that Doctor choose and employ such assistance he/she deems fit. I also understand that use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further agree that a 1½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

If you request your mail service be suspended for a period of time and your account has a balance, I agree to a fee of $1.41 to be charged to my account for each additional billing required until my balance is paid in full.

Our office files your insurance as a courtesy, not a obligation. I understand that it is my obligation to confirm my insurance eligibility, waiting periods, and benefits for myself and all dependents. I understand that this office cannot guarantee my insurance status in any of these areas. Any estimates or information given by this office is not a guarantee of actual insurance payment. I understand that if my plan does not pay a claim within 60 days of treatment, I will pay balance and seek reimbursement from my plan. In signing this form, I accept full financial responsibility for this account, for myself and all dependents.

THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND IS ONLY FOR USE IN MY TREATMENT, BILLING AND PROCESSING OF INSURANCE FOR BENEFITS FOR WHICH I AM ENTITLED. I WILL NOT HOLD MY DENTIST OR ANY MEMBER OF HIS/HER STAFF REPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM. I UNDERSTAND MY SIGNATURE WILL BE USED AS A 'SIGNATURE ON FILE' FOR INSURANCE PROCESSING.

Patient, Parent, or Responsible Party ___________________________________ **Date** ______