

Consent and payment agreements

Authorization for Release of Information

I authorize release of information regarding treatment planned or completed for me and my dependents to third party payors (such as insurance companies) and other health care practitioners. This information may include diagnosis, records, study models, records of treatment or examinations rendered, as well as other information deemed necessary by the requesting party.

Signature of Patient (or responsible party if patient is a minor)

Date

Assignment of Benefits

I authorize and request my dental insurance company to make payment directly to the dentist for services provided to me.

Signature of Patient (or responsible party if patient is a minor)

Date

Acknowledgment of Payment Responsibility

I understand that my dental insurance carrier may pay less than the dentist's fee for services provided. I understand that I am responsible for full payment of all services rendered on my behalf of my dependents.

Signature of Patient (or responsible party if patient is a minor)

Date

For your convenience, we accept all major credit cards for payment (visa, Discover, and MasterCard), as well as personal checks and cash.

Delinquent Accounts

I understand that payment for treatment is due at the time of treatment, unless alternative financial arrangements are made. I realize that failure to keep this account current may result in the dental office being unable to provide additional dental services. In the case of default on payment of this account, I agree to pay collection costs and legal fees incurred in attempting to collect on the past due account.

Signature of Patient (or responsible party if patient is a minor)

Date