Patient Name ____

CONSENT FOR SERVICES

As a condition of your treatment by this office, suitable financial arrangements must be made in advance. The practice depends upon payment from the patients for their dental care and financial responsibility on the part of each patient must be determined before treatment.

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 form or assist in making collections from insurance companies. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Any monies due for treatment not covered by insurance is the responsibility of the patient.

You understand that any fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the dental services rendered to me by this office, I agree to pay the fees for said dental services at the time said dental services are rendered, or within five(5) days of billing if credit shall be extended. 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.

We reserve the right to charge interest (12% per year) on all unpaid balances over 60 days.

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

I give this office the absolute right and permission to use my photographs/slides of my teeth for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides.

If patient is a minor, I do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

We reserve the right to charge for broken or cancelled appointments unless 48 hours notice is given.

I have read the above conditions of treatment and payment and agree to their content.

____________________________________	__________	________________
Signature of patient, parent, guardian or responsible party	Date	Relationship to Patient