Financial Consent

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. It is my responsibility to thoroughly understand the coverage and exceptions of my particular policy. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company or managed care company and I will be responsible at the time of treatment for payment of any applicable deductible and for my estimated co-insurance portion. I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 60 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.
All returned checks will be subject to a $25.00 returned check fee. Any account balances that remain unpaid for 90 days from the date of service shall accrue interest at the rate of 2% per month or 24% per year and may be referred to a collection company or attorney. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith. Should I choose to discontinue care before treatment is complete, partial refund will be determined upon review of my case.

Payment Options:

You can choose from: - Cash, Check, Visa®, MasterCard®, American Express® or Discover Card®

Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card

- Allow you to pay over time
- No annual fees or pre-payment penalties

I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith. I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient signature: _____ Date: _____
Print Name: _____
Guardian/Responsible Party, if minor: _____ Date: _____
Print Name: _____