Patient Consent

The undersigned hereby authorizes Doctor to take X-rays (radiographs), study models, photographs or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Patient/ Parent Signature: _____ Date: _____

Billing

____**Option 1**: (No Insurance)

All accounts are paid in full at the time of service. If you have insurance, we will be happy to process the insurance for you and payment will be made directly to policy holder.

OR

____**Option 2** (Direct Billing)

As a courtesy we will direct bill your insurance company provided a **credit card number** is left on file and payment will be made directly to our office. The patient is then responsible on the date of service to pay the difference not covered by their insurance. If we receive a claim acknowledgement, we will collect an estimated portion based on your insurance information.

If there is a balance less than $100.00 after insurance has paid, this credit card will automatically be charged. For outstanding balances over $100.00, we will inform you before processing the balance.

Visa/ Master Card _____ **Expiry Date:** _____ **CVV:** _____

Appointment Agreement

As a highly valued patient we trust that when an appointment is made to suit your schedule, you will make every effort to keep that commitment. We do respect your time, ours and the other patients in our office. Should a conflict arise, ***'please provide us with two business days'*** *notice.*

Patient Signature: _____ Date: _____

Office Authorization Signature: _____ Date: _____