PATIENT CONSENT

Clinical

1. I authorize 101st Family Dentistry to perform all recommended treatment

2. I authorize the Practice to take radiographs, study models, photos and other diagnostic aids or materials (collectively, Diagnostic Materials) as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third party payors and/or other health professionals.

3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to; redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

4. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered unless prior arrangements have been made with me in writing prior to such services.

5. I understand that should my account become delinquent, I will be responsible for all collection costs including attorney fees and collection agency fees that will be added to my account by the collection agency immediately upon default.

6. In cases of divorced parents, the parent bringing the child will deemed responsible for payment. Our office does not become involved with personal issues related to divorced/separated/unmarried parents.

7. A $50 missed appointment fee will be charged to my account for all missed appointments or last minute cancellation. 24 hour cancellation notice is required for all appointments.

8. It is our policy to submit any insufficient funds to the appropriate legal authorities. A $30 charge will be added to your account for any returned check.

9. We accept the following methods of payment for services rendered: VISA, Mastercard, Discover, American Express, Care Credit, Cash and Check.

10. This office will not be involved with any third party liability cases. We do not file automobile or home owner's liability policies. Services are to be paid in full by you and you would need to seek reimbursement from the liability company.

11. The Practice will assess a copy charge for all duplicate records and x-rays

Insurance

12. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

13. I authorize the Practice to submit claims for payment for services rendered or pre-authorization necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to Practice, the insurance benefits, providing assignment is accepted. I am responsible for keeping my account current, regardless of coverage provided.

CDC

14. 101st Adult Dentistry follows the guidelines regulated by the Center for Disease Control and Prevention. In an effort to secure the health and safety of our patients and their families, CHILDREN ARE NOT ALLOWED TO ACCOMPANY PATIENTS IN THE CLINICAL AREA.

I HAVE READ THIS PATIENT CONSENT AND AGREE TO ALL TERMS AND CONDITIONS PROVIDED HEREIN.

Patient's Name _____ Date _____

Patient's Signature _____

****If patient is a minor, please provide signature below acknowledging consent of parent/ legal guardian**

Signature _____Relationship_____ Date _____

**The parent/legal guardian must complete this form for the minor, provide consent for dental treatment and accompany the minor child during each dental visit. Treatment will not be provided for unattended children.