

Consent for Services

I understand that I will receive a careful examination and that my treatment options will be explained to me. I realize I may select no treatment, alternative treatment or ideal treatment as recommended by this office and consent to treatment and services as outlined. I also realize financial arrangements must be made in advance and should I default on those arrangements, I will accept financial responsibility for any cost incurred for treatment that I have been rendered. I understand that fees given are estimates only for dental care that can be extended for a period of up to six months after which time fee increases or decreases may be incurred. I understand also that billing fees and interest on unpaid balances may be charged to my account, if remittance of payment is not made on agreed upon dates. I grant my permission for this office to telephone my home or workplace to discuss dental, medical and financial matters related to this form. I understand that this office will insure the confidentiality of my health and financial information and will only release this information when necessary to health care providers involved with my treatment.

I understand that this office will assist me in filing dental insurance benefits on my behalf. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child to third party payors. I authorize and request my insurance company to pay directly to the dentist insurance benefits. I am aware that I am ultimately responsible for payment of all dental services and that my agreement with my dental insurer is between my dental insurer and myself. Should problems arise it is my responsibility to discuss these problems with my employer's benefits coordinator and any balances or non-insured fees will be paid by me.

I grant my permission to have this office perform radiographs (x-rays), study models, clinical photographs and any other test necessary for diagnostic purposes, clinical research, patient education, and case documentation or presentation. I authorize this office to release my diagnostic records and health information, only as needed, to other health care providers who may be involved with my treatment. It is our responsibility to provide you assurance that this information will be protected in accordance with HIPAA (Health Insurance Portability and Accountability Act) legislation designed to protect you.

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

Signature of patient, parent or guardian _____ Date _____