Dusty Rose DENTISTRY

**FINANCIAL AND CONSENT FOR SERVICES**

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

**As a condition of this office, financial arrangements must be made in advance.** The practice depends upon reimbursement from the patients for the cost incurred in their care, and financial responsibility on the part of each patient must be determined before treatment. Parents not accompanying their child to an appointment must make prior arrangements for payment.

_____ **I understand that payment is due in full before final delivery of any (Crowns, Dentures, Partials or any removable devices)**

_____**There will be as charge for any broken appointment without 48 hours' notice. This time allows us to make your appointment time available to another patient who is in need of dental treatment.**

_____**All emergency dental services, or any dental services performed without previous financial arrangements, MUST be paid for at the time services are performed.** I understand that my dental insurance is a contract between me and the insurance carrier and not between the insurance carrier and the dentist, therefore, **I am still responsible for ALL dental fees.** I understand that I will be charged for all dental treatment and that any payments received by the Dental Office from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred. **However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.**

_____If I do not pay the entire new balance within 30 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $1 for a balance under $10) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, **I promise to pay any legal interest on the balance due,** together with any collection costs and reasonable attorney fees incurred to effect collection of this accounts or future outstanding accounts.

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

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

_____ Date: _____ Relationship to patient: _____

Signature of Patient, Parent or Guardian


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