

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or provide documentation regarding treatment to insurance companies if necessary to expedite reimbursement to the patient. If I request that this office help with preparation of insurance claims, I authorize the release of any medical or other information necessary to process the claim. This dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that I may apply for a monthly payment plan through CareCredit or CapitalOne healthcare finance to cover dental expenses. Information regarding the terms and conditions of the monthly payment plans is available upon request.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

In order to ensure the lowest possible pricing and the highest level of service to you, we are implementing a new system that will reduce our billing costs yet maintain the quality of service that you require and deserve. All accounts that go beyond 60 days past due may be transferred to Transworld Systems, a national collection agency, for account receivable assistance. Should this be necessary, a service fee of \$20 may be added to your account as well as interest, if applicable.

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

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

Signature of patient, parent or guardian

_____ Date: _____

Signature of guarantor of payment/responsible party

_____ Date: _____