Authorization, Release, and Agreement to Pay for Services Required

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners.

I authorize and hereby request my insurance company to pay insurance benefits directly to the doctor otherwise payable to me.

I understand that my dental insurance carrier may pay less then the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Late Charges:

If I do not pay the entire new balance within the monthly billing date, an additional charge of 35% on the unpaid balance will be assessed. I realize that failure to keep this account current will result in the office being unable to provide additional services, except for dental emergencies where payment will be required prior to additional services. In the case of default on payment for my account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balances.

X_____ DATE _____

Signature of Patient or Parent (if minor)

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

Payment in full is expected at each appointment by the following:

_____ Cash

_____ Personal check w/ valid driver's license

Credit Card:

_____Visa _____Mastercard _____American Express _____Discover

We thank you for your cooperation.