

Authorization

Name of Patient: _____

I, the undersigned, hereby authorize payment of dental benefits, if any, directly to the Doctors. Payment or copayment is expected at the time services are rendered by cash, check, Mastercard, Visa, Discover or CareCredit unless other arrangements have been made with the treatment coordinator prior to services being rendered.

Dental Insurance: Regardless of the type of insurance coverage you have, the full amount of your account is the patient's or the guardian's responsibility. Your insurance claims are processed by our office, as a courtesy, at no charge. However, the contract is between the patient and the insurance company. Please notify the office promptly of any change in employment or insurance carrier.

Divorced and Separated Parents: The parent accompanying the patient to the visit is responsible for payment of the account.

All accounts 60 days past due and over will accumulate a finance charge of 1.5% per month or 18% annually.

I hereby agree that I, the undersigned, shall be liable for any reasonable attorney's and court fees and/or collection costs incurred by the Doctors in the event that such bills are placed with an attorney or third party.

I hereby authorize medical/dental surgical treatment, care and/or services by the Doctor to the above named patient.

I hereby authorize the Doctors to release any information acquired in the course of examination or treatment, **with my knowledge and consent.**

I hereby authorize any physician, health care practitioner, hospital or medical care facility to provide all information on the above named patient's medical history to the Doctors.

Twenty-four hour notice must be given if you cannot keep an appointment, otherwise a charge will be assessed.

I hereby authorize photocopies of this form to be valid as the original.

Signature: _____ Date: ____/____/____

Print Name: _____ Relationship to Patient: _____

If a patient is under 18 years of age, a parent or guardian must sign.