

Patrick R. Person, D.D.S.

Consent for Treatment and Financial Policy

Welcome to our dental office. We would like you to be familiar with our treatment and financial policies. The dental practice depends on reimbursement from the patients for the costs incurred in their care.

All dental services furnished are charged directly to the patient, and the patient is responsible for payment. This also applies to the patient's dependants. Our office will gladly file your insurance claims for you, but services cannot be rendered based on the assumption that our charges will be paid by an insurance company. Any fees over the allowance by your insurance carrier are the responsibility of the patient. Fee estimates for dental care can only be extended for 6 months from the date of the examination.

In the event that your account is placed with a Collection Agency, a collection fee of up to 33.3% may be added to your account and shall become a part of the total amount due. You will be responsible for any and all reasonable collection fees including attorney fees and court costs.

You agree, that in order for us to service your account or to collect any amounts you may owe, we and our collection agencies may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to us.

The dental staff might need to take x-rays, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. If treatment is recommended and accepted by the patient, the patient gives authorization to the doctor to perform all recommended treatment mutually agreed upon. Any treatment given might require the use of anesthetics, sedatives, and other medications as necessary. The patient understands that using these agents embodies certain risks. These risks can be discussed at your request.

We are glad to have you as a part of our dental practice! We look forward to caring for you and your dental needs.

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

_____ Date _____ Relationship to patient _____
Signature of patient
(Parent or guardian required if under 18 years of age)

_____ Date _____ Relationship to patient _____
Signature of guarantor of payment/Responsible Party