



FAMILY DENTISTRY, P.C.

CONSENT FOR SERVICES & FINANCIAL POLICY

Welcome to our dental practice! Please take a moment to familiarize yourself with the financial policies of our office. After you have had the opportunity to read this consent and have all your questions answered please sign to show your understanding of the stated policies. 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 in cash at the time services are performed. Family Dentistry, P. C. accepts cash, checks, Visa, MasterCard, American Express, Discover and Care Credit. There is a \$35 fee for returned checks. A confidential credit history from Memphis Consumer Credit will be requested for each new patient. This document becomes a part of your private financial record.

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 patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Any fees considered over the reasonable and customary allowance by your insurance carrier are the responsibility of the patient. The undersigned agree/s that he/she is responsible for charges incurrent on this account and if the account has to be placed with a collection agency or attorney that he/she will pay any and all reasonable costs of collection and/or attorney fees.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

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, or within five (5) days of billing if credit shall be extended. 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 and/or collection agency fees if suit be instituted hereunder.

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. Cancellation and No Show Policy – When an appointment is broken without 48 hours notice, it is customary for us to charge the patient a \$35 fee.

I consent to the use, publication, and copyright of Family Dentistry, P.C., in my patient record and, “in office” presentations and bulletin boards, of photographs in which the patient may appear as a patient in any services or activities offered by Family Dentistry, P. C.; and the foregoing consent shall extend beyond the patient’s consent for services signature date.

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