AUTHORIZATION/CONSENT

I authorize treatment and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon receipt, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for dental services rendered to me or my family, I/we agree to pay all attorney and/or collection fees.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection of the claims. A copy of this assignment is as valid as the original.

The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or agent to make a credit investigation, including employment verification. I understand that I am entitled to a copy of this report and may request it at any time.

SIGNATURE ON FILE

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I authorize Dental Care Associates to take photographs of me and my family members for our clinical charts. In no circumstance with the photographs be used for publication without written notice.

To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Signature_____ Date _____
(Patient, Parent, or Guardian)

***Remember that payment is due in full at the time of treatment unless prior arrangements have been discussed and approved.**

Dental Care Associates 4/17