CEDAR STREET
FAMILY DENTISTRY

Consent for Services

I hereby authorize the doctor or designated team member to take x-rays, study models, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance to provide proper care. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

The financial responsibility for services provided by this office is the patient's, their parent, their guardian, or other responsible party. As a courtesy to our patients who carry dental insurance, we will bill their insurance; however, this does not alleviate the patient's responsibility for payment in full of their account. The same policy applies to emergency services. At the time of service, the patient will be responsible for paying deductibles and co-pays. For your convenience in paying, we accept cash, check, Visa, Master Card, Discover, and American Express.

A service charge of 5% per month (20% annum) on unpaid balance will be charged on all accounts exceeding 60 days. I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the examination. Estimate cost may vary due to unforeseen circumstances.

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 service to said doctor, or the assignee, at the time said serviced are rendered. 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 fees if suit be instituted hereunder.

I grant my permission to you and your assignee, to telephone me at home, my work, or my cell phone to discuss matters related to this form. I have read the above conditions of treatment and agree to their content.

Signature: _____ Date: _____ Relationship to patient: _____

(Signature of patient, parent or guardian)