Authorization and Release

Patient Name: _____Patient DOB: _____

I understand my estimated portion for all treatment is due at the time services are rendered unless other arrangements have been made in advance. I authorize and request my insurance company to pay directly to the dentist or dental group the benefits otherwise payable to me.

I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants, regardless of insurance payment.

I understand it is my responsibility to notify the office of any changes in information given such as mailing address, phone numbers, insurance coverage, and medical changes.

I understand office policies as follows; missed and/or broken appointments without a 24 hour notice will result in a $25.00 fee per hour scheduled, there will be a monthly billing charge of $5.00 and a finance charge of1.5% per month which is an annual percentage rate of 18% charged on all past due accounts. Failure to keep account current may result in collection and/or attorney fees incurred in attempting to collect on outstanding balances.

Print Name _____ Signed_____

If minor Parent/ Guardian _____

Date_____