NJC DENTISTRY

CONSENT FOR GENERAL TREATMENT/ FINANCIAL AGREEMENT

Patient name (please print): _____

Diagnostics and Treatment

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employs any such assistance as he/she deems appropriate. _____initials

Third Party Release of Information

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others who may request my records. _____initials

Financial Policy

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins. _____initials

When working with dental insurance – NJC Dentistry will make every effort to provide me with an estimate of my co-pay based on the insurance information I have given them. I am responsible for verifying this estimate with my insurance company and for paying my estimated portion (co-pay) at the time of service. Once insurance claims are processed I am responsible for any uncovered portion of the balance. _____initials

Other Related Fees

Returned checks will be assessed a $20 processing fee. Appointments missed, cancelled or rescheduled within 1 business day (<24 hours) may be accessed a fee of $50. All balances over 30 days will bear interest of 1.50% ($1.00 minimum) per month. _____initials

Please do not hesitate to ask if you have any questions. Copies of any signed document may be requested at any time.

_____ _____

Patient signature or Parent/Legal Representative Date

_____ _____

Printed name/relationship if signing on behalf of patient Date

_____ _____

Admin Staff signature Date