CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Perry Patel D.D.S., to perform dental services for myself (or minor child), including but not limited to x-rays, exams cleanings, fillings, extractions, and crowns and administration of anesthetics, antibiotics, analgesic, or any other drug that maybe deemed necessary. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of these procedures.

Patient (patient/guardian) Signature_____Date_____

CANCELLATION POLICY

As a courtesy to our staff, we kindly request that a 24 hour notice be given if you cannot make it to your appointment. Appointments missed or cancelled with insufficient time will be charged a fee. The fee will be assessed according to the time the staff allotted for the appointment. Your cooperation and understanding is greatly appreciated.

PATIENT NAME_____

RESPONSIBLE PARTY NAME_____

RESPONSIBLE PARTY SIGNATURE_____DATE_____

FINANCIAL POLICY

As a courtesy we will bill your insurance however, we ask you to read carefully:

Due to all the various insurance plans now in effect, we require that you check with your insurance carrier(s) regarding our participation in your specific network. There are instances when even though we are contracted with a carrier, the carrier has networks in which we do not participate. If our office does not participate in your network, you will be responsible for a portion of the entire bill. **It is your responsibility to update us with any new card that you receive from your carrier.**

We will send your insurance carrier(s) a claim for all services provided. **Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. You will receive a statement from our office after your insurance has settled your claim if there is any balance due. Payments are expected within thirty days of receipt of the statement. Our office accepts cash, checks and Visa/MasterCard/Discover/American Express. There will be a $25.00 charge for any returned check.**

I have read and understand this policy.

***Signature*_____*Date*_____**

AUTHORIZATION FOR RELEASE AND USE OF PHOTOGRAPHS

I, the undersigned hereby acknowledge give Dr. Perry Patel, DDS., permission to use my name and photographs in connection with their educational and promotional activities as professionals in the field of Cosmetic Dentistry.

I, _____, am the parent or guardians of the minor named above and have the legal authority to execute the above release. I approve the foregoing and waive any rights in the premises.

Date_____ Signed:_____