

PATIENT CONSENT

Clinical

1. I authorize Scott Edwards, DDS, Greg Kemp, DDS & Julia Prince, DDS, to perform all recommended treatment. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.
2. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

3. I am responsible for payment for all services rendered on my behalf. I understand that I am responsible for all fees regardless of insurance coverage. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.
4. The parent or guardian noted as the responsible party on the initial visit for the Child's account is financially responsible. Note: regarding parents or guardians who are divorced, separated, or single; we are not in a position to mediate payment arrangements between parents or guardians _____(initials)

Insurance

5. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.
6. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: _____ Date: _____

Patient's Address: _____

If patient is a child, please provide the parental or legal guardian's consent:

Signature: _____ Relationship: _____ Date: _____

NOTE (MINORS): The parent or legal guardian must complete this form for a minor, provide consent for dental treatment and accompany the child during each dental visit. If the parent or guardian consented to treatment in advance, an authorized individual named on Page 1 may bring the child. Treatment will not be provided for unattended children.