

Rebekah A. Boral, DMD

CONSENT for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed must be paid at the time services are preformed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will prepare the patients insurance forms or assist in making collections from insurance companies and will credit and such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for six months from the date of patient examination.

In consideration for the professional services rendered to me, as per my request, by the Doctor, I agree to pay therefore the reasonable value of said services or said Doctor, or his/her assignee, at the time of services rendered, or within five (5) days of billing is credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me I 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 agree to a fee of \$50 for any appointment that is broken or not cancelled with a twenty-four (24) hour notice.

I grant my permission to you or your assignee, to telephone me at home or work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

Signature of patient, parent or guardian

Date: _____