

PATIENT CONSENT

CLINICAL

1. I authorize **CHAMBERLAND DENTISTRY, P. C.**, 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 payers 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 **payment is due when services are rendered.** I am aware that 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. A \$50 missed appointment fee will be charged to my account for all missed appointments or last minute cancellations by me. **I am aware that to hold down operating costs, 24 hour notice of cancellation is required.**

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 the terms and conditions herein.

Patient's Name: _____ **Date:** _____

Patient's Address: _____

Patient's Signature: _____ **Relationship:** _____ **Date:** _____

(If patient is a child, please provide the parental or legal guardian's consent signature above.)

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/listed on PHI may bring the child. Treatment will not be provided for unattended children...no exceptions will be allowed.