

Consent for Services

I hereby authorize and consent to the performance of dental treatment which Dr. Sandquist and I agree are necessary. This consent shall remain in effect until I choose to revoke it in writing.

I authorize release of any information relating to this treatment. I understand that I am responsible for all charges not covered by my dental insurance. I authorize payment directly to Dr. Sandquist unless otherwise noted.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any 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.

I further agree that if this account becomes delinquent, a finance charge of 1.5% will be added to my account balance after 90 days collecting the same, including court costs, reasonable attorney fees and/or collection agency commissions or charges.

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

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

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

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____