All patients please read the following . . .

Payment for services is expected at the time service is provided. Cash and personal checks are accepted. If an extended payment plan is desired, please ask us about CareCredit or other finance programs. MasterCard, Visa, and Discover credit card payment are also welcome. If you have any questions, please feel free to ask.

I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all past due amounts at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collection, a collection fee will be added.

If you have dental insurance . . .

As a courtesy, we will file your claim for you. We may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due our office may be adjusted accordingly. You may find that our fees may be different from the insurance company's schedule of "allowable" or "UCR" fees. If you have questions about "UCR" fees, please feel free to ask. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

_____ I acknowledge receipt of the Notice of Privacy Practices describing HIPPA regulations

_______________________________________ ____

Print name Signature & Date

Consent for Treatment:

I hereby authorize the doctor or designated staff member to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient. Upon such diagnosis, I authorize the doctor or designated staff member to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I have read, understood, and agree to the above treatment policy.

Patient, Parent or Guardian Signature:____________________________ Date:________________

Records Release:

I hereby authorize the following person(s) to obtain copies of my recommended treatment and/or information about my dental visits.

Name:___________________________________ Relationship:______________________________

Name:___________________________________ Relationship:______________________________

Name:___________________________________ Relationship:______________________________

It is my responsibility to inform the dental office of any changes in medical status. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Patient, Parent or Guardian Signature:__________________________ Date:_________________

Email: info@owassosmiles.com Website: www.owassosmiles.com