Consent for Service

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

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 unless other arrangements are made.

Patients with dental insurance understand that their balance is an estimate from the information given to our office by their insurance company. Rivers Edge Dental will submit dental claim to the insurance company and the patient is personally responsible for the estimate payment at the time of service and any balance that may accrue after insurance process claims. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.66% per month (20% 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 any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional service rendered to me by this practice, I agree to pay the charges for the service at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, with the time payment is due. 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 grant my permission to you or your assignee, to telephone me to discuss this statement or treatment.

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

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to Patient: _____