Q Dental Care
for absolute quality

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. If you have dental insurance and our office participates, we will accept assignment from your insurance company for any **covered** treatment. **We require payment in full for any uncovered portion (co-payment/deductible) of your care at the time of your appointment.** An ***estimate*** of the amount due from you will be calculated when the appointment is scheduled or by a preauthorization from your dental insurance company.

If you do not have dental insurance or we cannot verify eligibility from your insurance carrier, **payment is due in full at the time of your appointment. We verify benefits as a courtesy only and strongly encourage that you ALSO confirm coverage.**

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.

A service charge of 2% per month (24% 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 a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in 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 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.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Q Dental Care
for absolute quality

Contact Information

Please complete all to the best of your ability and please choose your preferred Method of Confirmation (choose one):

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Text Message: _____ **(not currently available but is appreciated for future reference).**

Personal Reprehensive Information (If Applicable)

_____ _____
(Print Name of Patient's Personal Representative) **Relationship to Patient**

Acknowledgement of Receipt of Notice and Consent to Use and Disclose Health Information (Privacy Policy)

Release of Medical/Dental Information—Assignment of Benefits

I have reviewed a copy of AQ Dental's Notice of Privacy Practices. A copy of this office's Notice of Privacy Practices has been made available to me. I agree and authorize AQ Dental to use and disclose pertinent information about me for treatment, payment and healthcare operation purposes. I hereby authorize payment for services directly to AQ Dental. I further authorize the signature below can be utilized as a "signature on file" for the sole purpose of submission of insurance on my behalf.

Patient Name_____**Date**_____

Patient Signature_____
Signature of patient, parent or guardian

Personal Reprehensive Information (If Applicable)

_____ _____
(Name of Patient's Personal Representative) **Relationship to Patient**