

Consent for Services

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

Payments for treatment must be received on or before the day of the scheduled appointment, before services are performed. In the event that the patient is unable to make payment, a no show fee will be charged, and the appointment will be rescheduled under the discretion of the Doctor. _____ **(please initial)**

Acceptable forms of payment include, Cash, Visa, MasterCard, American Express, Discover, CareCredit, and Capital One.

Personal checks will not be accepted. _____ **(please initial)**

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. Checks will not be accepted.

A service charge of 1 1/2% per month (18% 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 assuming that insurance rates have not increased. If insurance plan rates are increased, this extension is void. 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 service 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 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.

_____ Signature of patient, parent, or guardian	_____ Date	_____ Relationship to patient
_____ Signature of guarantor of payment	_____ Date	_____ Relationship to patient

Appointment Cancellation Policy

If you are unable to keep your reserved appointment, we ask that we be given 2 business days' advance notice. For appointments cancelled on the day of, or outside of the 2 business days, a \$25.00 cancellation charge will apply. For patients who fail to show to an appointment within 10 minutes of the reserved appointment time, a \$50.00 no show charge will be applied to their account and due prior to scheduling future appointments. In addition, patients who come to their appointment unable to make payment will not be seen, and will be charged a no show fee. Patients who fail to show to more than 2 appointments may be asked for a deposit to reserve their appointment time. Please sign below as confirmation that you have been notified of our cancellation policy.

_____ Patient name (Please print)	_____ Patient Signature
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DMFS (The Facts About Fillings)

I, _____, acknowledge that I have received a copy of the
 (Please print above)

Dental Materials Fact Sheet dated May 2004, from Pries Dental Care.

Signature: _____ Date: _____