General Consent Form

Patient Name: _____ Date: _____

General Consent:

Please note that all paper work must be completed and signed. We retain the right to refuse service to anyone not willing to complete the appropriate paperwork or provide consent. This consent may be updated periodically and the most current version can be found on our website philpfamilydentistry.com.

I hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I understand that my doctor will discuss treatment with me. I authorize and consent that the doctor employs any such assistance as she deems appropriate.

Financial Consent:

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. **I understand that payments are due the day that service is rendered and agree to make an additional payment that might be due on my account after insurance has paid their part. I understand that any other arrangements for payment must be made before treatment begins.**

I understand that when I make an appointment, this time is specially reserved for me, and it is my responsibility to make proper arrangements to ensure that I make my appointment. Appointments that require a length of greater than 90 minutes may require pre-payment. I understand that missed appointments with less than 24 hours' notice may result in a failed appointment fee, billed at a rate of $90/hour, that I am responsible for.

Insurance Consent:

I certify that the insurance information I provided is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and myself. **I understand that an estimated portion is due at the time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed, by my insurance company.** I understand my portion may be more if my insurance company does not pay the anticipated amount. **I also understand that services are rendered independent of insurance reimbursement.**

Patient/legal representative signature: _____ Date: _____

Printed name if signed by legal representative: _____