CONSENT

The undersigned hereby authorizes Dr. Finkelman to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Finkelman to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Finkelman to perform any and all forms of treatment, medications, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

==

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. All patients must complete this form and bring their Insurance card or the necessary information for an accurate filing with the insurance company on the appointment day or you will be responsible for total services rendered.

FULL PAYMENT IS DUE AT TIME OF SERVICE IF YOU DO NOT HAVE INSURANCE.

We will accept assignment of insurance as a courtesy to you, however the balance is your responsibility whether you're insurance pays or not. Please remember that dental insurance is a contract between you and the insurance company and usually is not designed to pay the true value of treatment, but provide coverage for only a portion of the cost of dental services. We are not a party to that contract. In the event we do accept assignment of benefits, and if your insurance company has not paid your account in full within 90 days, the balance will automatically be due and payable by you. If for any reason your balance is transferred to a collection agency, you will be responsible for any applicable fees. However, we will do all we can to help you and collect from your insurance company.

When it comes to your insurance don't be surprised, always be right, by making sure you understand and are familiar with your dental coverage.

A FEE OF $25.00 WILL BE CHARGED FOR BROKEN APPOINTMENTS UNLESS 24 HOURS NOTICE IS GIVEN.

I CERTIFY THAT I HAVE READ AND AGREE TO THE FINANCIAL POLICY AS STATED ABOVE AND THAT ALL QUESTIONS CONCERNING THE ABOVE POLICY HAVE BEEN ANSWERED TO MY SATISFACTION.

Signature X ______________________Patient's Name___________________________ Date____/_____/____

I assign my insurance benefits to the provider listed above.