Authorization and Release

I certify that I have read and understand all information to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment of examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me and on my behalf of my dependents.

APPOINTMENTS: Once an appointment is made, please remember that you are confirming that the time is reserved for you. A minimum charge could be made for failed or cancelled appointments without 24 hour notification.

PAST DUE ACCOUNTS: In addition to the outstanding balance due, we reserve the right to charge a late fee of 1½% per month against the unpaid balance for amounts outstanding over 90 days. This is in accordance with the Truth in Lending Law. Patient will also be responsible for any legal fees and court expenses incurred in collection any outstanding balances.

RETURNED CHECK: We reserve the right to assess a $35.00 service charge to be paid in cash, in addition to the returned check. I understand that credit bureau reports may be obtained in case financing of treatment is requested.

X _____

Signature of Patient or Parent (if minor)