

LifeSmiles of New Hope, P.C.

INFORMED PATIENT CONSENT

Treatment

I hereby consent to the treatment as agreed upon, to the taking of dental x-rays for diagnostic purposes, and to the use of local anesthetics, relaxants, gas or a combination of both for completing the treatment.

Signature of Patient or Responsible Party

Date

Payment

It is expected that payment for all treatment be made in full when services are rendered. For your convenience, we offer the following methods of payment: cash, check, Visa, MasterCard, American Express, or Discover. If you have any questions concerning financial arrangements or need special arrangements, please notify the financial coordinator.

Authorization Release, and Agreement to Pay for Services Rendered

I authorize LifeSmiles of New Hope, P.C. to release any information, including the diagnosis and records of treatment or examination, to third party payers and/or other healthcare practitioners.

I authorize and hereby request my insurance company to pay directly to LifeSmiles of New Hope, P.C. insurance benefits which would be otherwise payable to me.

I understand that my dental insurance carrier may pay less than total charges for services rendered by LifeSmiles of New Hope, P.C. I agree to be responsible for complete payment of all services rendered on my behalf or that of my dependents.

Signature of Patient or Responsible Party

Date

Late Charges

If I do not pay the entire new balance within 90 days of the monthly billing date, a late charge of 1.5% will be assessed on the outstanding balance each month. I realize that failure to keep my account current may result in LifeSmiles of New Hope, P.C. being unable to provide additional dental services unless I experience a dental emergency or prepay for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on my account.

Signature of Patient or Responsible Party

Date

Appointment Times

We see all patients on an appointed time and ask that you call to schedule appointments so that we may reserve time for you. We respect your time and will make every effort to remain on schedule and ask that you extend the same courtesy to us. If you are unable to keep a scheduled appointment, please notify us immediately. We appreciate 24 hours notice so that the time may be given to another patient. We reserve the right to charge a broken appointment fee of \$50 for appointments cancelled without 24 hours notice.

I have read and understood the policies of LifeSmiles of New Hope, P.C. and agree to follow them. I realize that if I have any questions or concerns at any time, one of the staff members or one of the doctors will be happy to assist me.

Signature of Patient or Responsible Party

Date