SHINE PEDIATRIC DENTISTRY

Patient_____ **Date_____**

Welcome to the Practice. Thank you for choosing Shine Pediatric Dentistry. We are so happy you are here. We will do everything we can to make your visit with us a very pleasant experience. Let us know how we can further assist you.

CONSENT

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

TERMS AND CONDITIONS

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. We will collect your estimated copay responsibility at the time of your visit and bill your insurance for the remaining amount. **Once your insurance pays their portion any remaining balance will be billed directly to the responsible party.** This office is not a party for any divorce decree. The responsibility of minors rests with the accompanying adult and responsible party signing below.

Insurance Authorizations

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefits to the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below name dentist or dental entity

COLLECTION AUTHORIZATIONS

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand upon non-payment for service and in the event of multiple billing, I will be assessed a rebilling fee of $35.00. I, the undersigned here by agree that in the event of default in the payment of any amount due, and if this account is placed with a collection agency, for collection or any subsequent legal action, to pay an additional collection fee of 30% of the account balance due, as well as any attorney fees and court costs incurred and permitted by laws governing these transactions.

THERE MAY BE A CHARGE FOR ANY MISSED APPOINTMENTS OR APPOINTMENTS NOT CANCELLED 48 HOURS BEFORE THE APPOINTMENT TIME

By signing below I certify that I have read, understand and agree to all of the guidelines and authorizations mentioned above.

Signature of Responsible Party_____ Date_____

Signature of Patient _____ Date _____