

## **CONSENT AND FINANCIAL RESPONSIBILITY**

Thank you for choosing us for your family dental needs. We are committed to giving you the highest quality of care in a safe environment. The following is a statement of our financial guidelines so that you may have a written statement of your financial options.

### **\*Payment Options**

Payment is expected at the time of service. In the case of a minor, the parent or guardian that accompanies the patient is responsible for payment. For your convenience, Sandy Point Dental will accept a personal check, cash, Visa, MasterCard, Discover, or CARE CREDIT (Dental Credit Option).

### **\*Patients with Insurance**

Sandy Point Dental is happy to submit claims to your insurance as a courtesy to you. We will estimate what your portion will be based upon the percentages your insurance has provided us. Your estimated portion is due at the time of service.

### **\*Appointments**

We understand that your time is very valuable, as is ours. Children under 18 must be accompanied by an adult. Sandy Point Dental reserves the right to charge \$50.00 for any appointment cancelled or missed with less than 2 business days notice. Additionally, patients who fail to arrive in a timely manner may also be charged the missed appointment fee.

### **\*Consent**

The undersigned hereby authorizes Doctor to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of patient) \_\_\_\_\_, and further authorize and consent that doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

The staff at Sandy Point Dental is excited about helping our patients, and is motivated to achieve outstanding results. We would like to thank you for the trust you have placed in us with your dental care. If you have any questions about payment or financial responsibility, please ask our front desk staff. Fees are subject to change without notice.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Staff member \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

9/30/2007