WEST COBB
DENTAL STUDIO

Payment Agreement Form/ Consent for Services

NAME OF PATIENT: _____ DATE:_____

I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to the Practice at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and copays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered.

I understand that the Practice may charge:

1) a late fee if payment on my account is not received by the due date;
2) an amount equal to $35 per hour, but not to exceed the maximum amount permitted by law for each returned check, and
3) a fee for each appointment that is missed/canceled without at least 24 hours advanced notice.

I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable.

RESPONSIBLE PARTY:

Full Name: _____ Married Single Child Other:_____ (circle one)

Social Security #: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip:_____

Home Phone:_____ Work phone: _____

Employer Name: _____ Occupation: _____

Address: _____ Phone: _____

INSURANCE INFORMATION:

Primary Insurance:

Name of Insured: _____ Is Insured individual a patient? **YES** or **NO** (circle one)

Insured Individual Birth Date: _____ ID #: _____ SS#:_____ Group#:_____

Insured Employer Name: _____

Insurance Plan Name & Address: _____ (Name)

_____ (Address)

_____ (Phone Number)

Secondary Insurance:

Name of Insured: _____ Is Insured individual a patient? **YES** or **NO** (circle one)

Insured Individual Birth Date: _____ ID #: _____ SS#:_____ Group#:_____

Insured Employer Name: _____

Secondary Insurance Plan Name & Address: _____ (Name)

_____ (Address)

_____ (Phone Number)

Patient's Relationship to insured (circle one): **Self** **Spouse** **Child** **Other:** _____

I hereby authorize West Cobb Dental Studio to administer such medications and perform such diagnostic photographic and therapeutic procedures as may be necessary for proper dental care.

I grant the right to West Cobb Dental Studio to release my dental/medical histories and other information regarding my dental treatment to third party payers and other health professionals

I grant my permission to you or your assignee, to telephone/text me at any of the numbers I have provided to discuss matters related to my treatment and appointments unless I specify otherwise . I have given the office correct phone numbers and address and will be given a courtesy reminder at the numbers I have provided. It is my responsibility to confirm and arrive at my appointments as scheduled.

The information I have provided on this form is correct to the best of my knowledge

I have read the above conditions of treatment and payment and agree to their content

I acknowledge having received a copy of the Practice's Notice of Privacy Practices . I agree that a photocopy of this authorization is as valid as the original.

Signature of Responsible Party: _____ Date: _____