SMITH Dental Care

Joshua Smith, DMD

Consent Form and Financial Agreement

Please Read, Health Questionnaire and Acknowledgement with Consent to Proceed:

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Joshua Smith and/or such associates or assistants as he may designate, to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments

I understand that the administration of local anesthetic may cause an untoward reaction or side effects which may include but are not limited to, bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me as necessary and I have been given the opportunity to ask questions.

_____ _____ _____

Signature of Patient, Parent or Guardian *Date* *Relationship to patient*

Please Read, Office Policies and Federal Truth-in-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. Patient co-payments (the amount not covered by insurance) are due and payable at the time of service.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our Patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1.5% per month (18%per annum) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service. Fee estimates for dental care can only be extended for a period of six months from the date of patient examination.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay the reasonable value of said services to said dentist or his assignee at the time services are rendered, or within thirty (30) days of billing if credit shall be extended. I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit is instituted hereunder to collect monies owed by me, including interest charges, processing fees or commissions (up to 50% of principle) that may be assessed by any collection agency retained to pursue this matter.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters relating to this form.

I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Dr. Joshua Smith.

I certify that I have answered all questions of the form accurately and hereby agree to abide by the conditions outlined there in.

_____ _____ _____

Signature of Patient, Parent or Guardian *Date* *Relationship to Patient*