Treatment & Insurance Consent

<u>Purpose</u>: This form is to obtain an individual's written permission under Wisconsin law for our use and disclosure of the individual's dental care records to carry out treatment, payment activities, and health care operations.

Payment Information:

Who will be responsible for paying this account?______________________________Tel._____________
Mail statement to____
Do you have Dental insurance (please circle) Yes No
Policy and Numbers____
Social Security No._________________________

I choose to pay by:

__ Cash/Check
__ Credit Card
__ I want to discuss payment______________________________________

Consent and Agreement to Pay:

The undersigned hereby authorizes the staff of Cedarburg Family Dentistry to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the staff of Cedarburg Family Dentistry to make a thorough diagnosis of the patient's and/or dependents dental needs and to release them to appropriate insurance companies and interested parties and for disaster relief purposes as permitted by law. If patient is a child, I authorize a picture may be taken of my child. I also authorize the staff of Cedarburg Family Dentistry to perform all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents and dental procedures embodies risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, as agreed above, regardless of insurance coverage. The staff of Cedarburg Family Dentistry may use professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

I agree to make payments at least monthly, and to be personally responsible for the payment of all services rendered on my behalf and my dependents, if the person above listed as being responsible fails for any reason to do so. If I fail to give 24-hour notice of appointment cancellation, I consent to being billed for that appointment time at your office's discretion. In the event a quotation of fees is not given to me before the services being performed, I shall ask for such quotation or waive my right to later claim the fee exceeded the value of the services rendered. I understand that if credit is extended, it is done so on the basis of the financial information herein or otherwise obtained from me. In the event that payment for dental services is not made within thirty (30) days of receipt of statement, then interest at the legal prevailing rate plus a service charge may be added to the past due balance. If such agreed monthly payment is not made and, unless I dispute the amount owed in writing within sixty (60) days following the date of service, I agree, upon reasonable notice, to transfer of the amount due to a bank card listed above for payment. If collection services or legal services are required to obtain payment of the amount billed, I further agree to pay for all legal fees and costs reasonably incurred in connection therewith. Interest not paid when due shall be added to and become part of the principal.

I have received a copy of this office's Notice of Privacy Practices. I have read and understood this document and will provide consent for the matters discussed in it about my health care. I have the right to refuse to sign this acknowledgement and understand, subsequently, treatment may be withheld or declined. The undersigned has had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am confirming my written permission for the disclosure of my protected health information. Revocation of this consent will be accepted, in writing, delivered to our office's address, having no affect on services provided before revocation of this form.

Patient Signature (Parent of Child)__________________________Date:_____________
Must be Signed Before Treatment

Representative's Name & Relationship to Patient________________________________