MODERN DENTISTRY
of Shrewsbury

CONSENT FOR TREATMENT, INSURANCE PAYMENT AUTHORIZATION AND FINANCIAL POLICY DISCLOSURE

My signature below shall serve as my informed consent to perform all recommended treatment. It shall also serve as authorization to assign any dental benefits paid by any third-party of insurer to my provider. If I have insurance, I agree to make a payment of my estimated co-payment **at the time services are rendered**. I understand that estimated co-payments are **estimates only**, subject to policy maximums, limitations, and coordination of benefit rules.

After insurance pays their portion, a statement will be sent if there's a remaining balance. Any difference not paid by the insurance is expected to be paid by the patient.

This office will help prepare insurance forms and assist in making collections from insurance companies; however, **payment is ultimately the patient's sole and exclusive responsibility** should the insurer or third-party payer fail, refuse or otherwise neglect to make payment. All collections from third-parties or insurers will be credited to the patient's account. If I do not have insurance, all fees for services rendered are due on the date of service unless prior arrangements have been made in writing.

This office reserves the right to charge **a $75 fee for appointments missed or cancelled with less than 24 hours advance notice**. This fee may increase at the office's discretion based on the amount of time reserved for the patient. We reserve the right to collect a deposit for appointments over 1 hour in length.

In consideration for the professional services rendered to me by Modern Dentistry of Shrewsbury, I agree to pay the reasonable value of said services to the Doctor or his assignee, at the time services are rendered or within 15 days of billing if credit is extended.

I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I agree to pay all costs of collection, including attorney's fee and expenses, incurred to collect any unpaid fees.

I, _____, have read the above text and fully understand it.
(Patient/ responsible party's name)

Signature: _____ **Date:** _____