Crafton Family Dentistry

Consent for Treatment and Responsibility of Fees

1. I, _________________, hereby authorize Crafton Family Dentistry to perform upon me the dental treatment procedures listed in the treatment plan.

2. If any unforeseen condition arises in the course of dental procedures calling for, in the dentist's judgment, additional or different procedures/techniques form from those I have consented to, I further request and authorize Dr. Crafton to perform the procedures that he deems necessary.

3. The nature and purpose of dental procedures, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantee or assurance has been made as the results that may be obtained by the dental treatment procedures.

4. I acknowledge that no guarantee or assurance has been made that the treatment plan will be completed as proposed. I understand that if my dental needs change, the proposed treatment plan will change as well.

5. I understand that Crafton Family Dentistry operates on a "fee for service" basis and that fees are payable at the time of service.

6. Our office will gladly process your insurance claims, however, all deductibles and co-payments are due at the time of service. We can only estimate what your insurance will cover, even if the patient exceeds their yearly maximum. I understand that I am responsible for all the fees not paid by the insurance company.

7. Crafton Family Dentistry reserves the right to charge $50.00 for any returned check.

8. Crafton Family Dentistry has the right to charge a cancellation fee if the patient fails for an appointment, or cancels as appointment with out a 24 hour notice.

9. In the event that account balances are turned over for collection, the patient is responsible for all court costs, attorney fees, and all costs associated with collecting a debt. We also reserve the right to charge 1.5% interest per month to any account that is not paid in full within 30 days.

10. I authorize Crafton Family Dentistry to release any information and records concerning my treatment, as may be necessary to process claims or obtain payment for the treatment provided.

11. I have completed my medical history to the best of my knowledge. I understand that providing incorrect information can be dangerous to everyone's health. I understand that it is my responsibility to inform Crafton Family Dentistry of any changes in medical status.

_________________________________ ________________

Signature of Patient or Legal Guardian Date