

Patients Name: _____ **Date** _____

Consent

1. I authorize Dr. James Howard and staff to take all necessary X-RAYS, STUDY MODELS AND OTHER DIAGNOSTIC AIDS as needed to make a thorough diagnosis.
2. I authorize Dr. James Howard to PERFORM ALL RECOMMENDED AND AGREED UPON TREATMENT. I also authorize the use of anesthetic (As needed and I am fully aware that using anesthetic agents involves certain risks.
3. I AM RESPONSIBLE FOR ALL SERVICES RENDERED ON MY BEHALF AND MY DEPENDENTS. I am aware that a 1.5% finance charge is automatically tabulated if my account is 60 days or older. Should my account become delinquent, I will assume all additional collection costs and legal fees.
4. I understand that a BROKEN APPOINTMENT FEE will be charged to my account when I have missed/cancelled more than one appointment in a calendar year without cancelling/ rescheduling at least 24 hours prior to the appointment time. The amount of the broken appointment fee will be \$25.00. Please be courteous and cancel in advance if you are unable to make it to your appointment. If we know in advance we can contact someone on the stand-by list to come in at your appointment time.

Signature of Patient/ResponsibleParty _____

Financial Statement

I understand that I am responsible for the entire cost of treatment. I further understand that if it ever becomes necessary for this account to be turned over for collection, I am responsible for any collection and/ or attorney fees.

Insurance Statement

I authorize the release of any information needed to process my insurance claims. I further understand that I am responsible for the entire cost of treatment regardless of insurance coverage or payments. I authorize payment of insurance benefits directly to the dentist otherwise payable to me.

Acknowledgement of Receipt of Privacy Practices Notice

I hereby acknowledge that I have received a Notice of Privacy Practices from the office of Dr. James Howard.

Signature of Patient/Responsible Party: _____

Written Financial Policy

Howard Dentistry has several payment options available. You can choose to pay by cash, Visa or MasterCard. We also offer CareCredit that allows you to pay over time with convenient, low monthly payments. (Subject to credit approval)Howard Dentistry requires payment prior to completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

Patient, Parent or Guardian Signature