Dr. Robert J. Stancill, DDS, MS, PLLC

Practice Limited to Endodontics

4601 Lake Boone Trail, Ste 2A

Raleigh NC 27607

General Consent for Treatment: This certifies that I, whether signed as a guarantor or as the patient, voluntarily consent to the administration and performance of diagnostic procedures and dental treatment by authorized staff, that in their professional judgment, are deemed necessary or beneficial. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment.

Authorization to Release Dental Information: I hereby authorize Dr. Stancill and authorized staff to release my dental records and/or other protected health information, including copies concerning treatment, to but not limited to the following for the purpose of, among other things, processing insurance claims for payment of dental expenses incurred and to serve the goal of continuation of care:

- Insurance companies
- Dental or healthcare providers responsible for further care or follow-up treatment
- Utilization review organizations contracted by my employer, insurance company, governmental agency or program

Assignment of Insurance Benefits: I hereby authorize payment directly to Dr. Stancill of any benefits due for dental services rendered. I understand that my insurance is a contract between myself and my insurance company. I understand that Dr. Stancill and his staff have no control over what insurance "covers" or "how much" they may pay for a given procedure. I am financially responsible to Dr. Stancill for all charges regardless of insurance benefits. Any claim not paid within 60 days of treatment will be my responsibility. It is also my responsibility to verify my dental benefits prior to treatment. I understand that Dr. Stancill does not participate in any insurance network and I understand that this may affect my benefits. **There are many different insurance companies and plans; it is important that you understand your benefits available for your particular coverage.**

Financial Agreement: Whether signed as a patient or as a guarantor, I do hereby guarantee payment to Dr. Stancill for all charges incurred for services rendered. In the event that the undersigned fails to pay any fees due and the account is turned over to a collection agency and/or attorney for collection, I do hereby agree to pay all collection costs and expenses.

I, the undersigned, certify that I have read and understand and agree to the foregoing. I further certify that I am liable to Dr. Robert J. Stancill, DDS, MS, PLLC under the financial and office policy provisions herein stated above.

Signature_____ Date_____

Printed Name:_____