Consent for Services –Notice of Privacy—Responsibility of Payment

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. **Any payments collected in the office at the time of services are based on estimates only. Any treatment not covered by my insurance is my responsibility to pay.** I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient estimation.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five(5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. 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 further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I authorize Lim Family Dentistry to release my records and other pertinent personal information to other doctors to whom I have been referred.

My signature below indicates I have received a copy of the Privacy Practices for Lim Family Dentistry.

_____Date:_____Relationship to Patient:_____

Signature of patient, parent, or guardian

My signature below indicates I have read the above conditions of treatment, insurance, and payment and agree to their contact.

_____Date:_____Relationship to patient:_____

Signature of patient, parent, or guardian