HADA family dental

**Patient's Consent for Services**

**CANCELLATION/MISSED APPOINTMENTS**:
**As a courtesy, we respectfully request a minimum 48 hour notice for changes in appointments.**

**FINANCE CHARGE:** I understand that a finance charge of 1.75% per month (21% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days. This includes accounts waiting for insurance companies to pay. The minimum charge will be $2.

**INSURANCE:** Patients who carry dental insurance understand that all dental services are charged 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.

**AUTHORIZATION**:
1. With my signature below, I authorize and give consent for services to Dr. Hada and his staff to perform any and all procedures that I have agreed to both verbally and in writing.
2. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I have received a copy of this office's Notice of Privacy Practices.
3. I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my or my dependent's behalf regardless of insurance estimates.
4. If my account is assigned to an attorney or collection agency for collection and/or suite. This office shall be entitled to reasonable attorney's fees and costs of collections by me.
5. I hereby authorize this office to use any photos and/or testimonials by me for use in publications, advertisements, websites, exhibit booths, educational programs, other media and other ways as deemed appropriate by this office.

I have read the above conditions of treatment and agree to their content.

_____ _____
Patient Name (please print) Parent or Guardian Name (if patient is under 18)

**x** _____
Signature Date