CONSENT FOR SERVICES

PATIENT NAME:_____

IMPORTANT: A WORD ABOUT OUR PAYMENT POLICY

To help control escalating healthcare costs we do not routinely send monthly billing statements to our patients. As a condition of your treatment by this office, you are asked to pay your patient portion at the time of service. We accept cash, checks, debit & credit cards. Upon approval, monthly payments are accepted through our private finance company. I understand that the estimated fees quoted for dental care can only be extended for a period of six months from the date of the patient's consultation.

MINOR CHILDREN/STEPCHILDREN

Lowell Family Dentistry provides dental care to children of all ages. We reward our young patients for good behavior with verbal praise & novelty prizes. *Please be aware that some novelty prizes are small or contain small parts that can pose a choking hazard.* By allowing your child to accept prizes you are releasing Lowell Family Dentistry and its employees from any liability of said action**.** (We recommend that you assist your child in selecting prizes that you feel are age appropriate for each of your children) **If you do not want your child to receive prizes, it is your responsibility to notify our staff at each appointment.** As a parent/guardian you are accepting responsibility for your child's conduct while in our office. Please do not leave your child unattended. If you have older children who are able to come to their appointment unattended, please make sure they are prepared to pay their patient portion at the end of their visit. We accept cash, checks, debit & credit cards. In order to see your child we require an **original signature from both parents before treatment is rendered regardless of your marital status.** If you are a parent or stepparent of a minor child you understand that you are responsible for billing/collecting from the non-custodial or financially responsible parent of your minor child. Lowell Family Dentistry cannot act as an agent on you or your child's behalf to collect or enforce court ordered payments or responsibilities.

INSURANCE CLAIMS:

Patients who carry dental insurance understand that while we do accept assignment of benefits from your insurance company, all dental services furnished are charged directly to you the patient and that you are personally responsible for payment of said services. As a courtesy, we will file claims on your behalf with your insurance company. However, we must emphasize that we provide this service as a courtesy. Responsibility for collection of that claim is yours. Lowell Family Dentistry does not accept responsibility for collecting payment on your claim or negotiating a settlement on a disputed claim. If you have questions regarding your claim, please contact your insurance company. Lowell Family Dentistry does not participate in HMO, PPO, "Group", or "Network" plans. It is the your responsibility to access "in-network" providers. Failure to access "in-network" providers may result in reduced benefits. Lowell Family Dentistry will not be liable for reduction in benefits, payment, or denial of claims.

ACCOUNT CHARGES

Balances older than 30 days will be subject to a $10 monthly late charge unless previously written financial arrangements are made and are current. Appointments must be cancelled within a 12-hour period to avoid a "Failed Appointment" charge of $25 on your account. Late cancellations will be accepted in "emergency" situations only. Repeated and/or chronic cancellations may be assessed a cancellation fee of $50. A "Failure to show with failure to cancel" fee of $50 will be charged to your account if you fail to contact us and do not attend your scheduled appointment. Please notify us immediately when you are unable to attend your scheduled appointment time. For your convenience our answering system is on 24-hours a day to receive your call.

COLLECTION ACCOUNTS

If charges incurred at Lowell Family Dentistry have been turned over to a collection agency, you will be asked to pay cash for all services and supplies before you receive them. Lowell Family Dentistry may decide to terminate our physician-patient relationship with you due to non-payment. If the professional relationship is terminated, you will receive written notification. Emergency services only, will be provided for thirty (30) days after termination.

BANKRUPTY

If Lowell Family Dentistry has been included in your bankruptcy, you will be asked to pay cash for all services and supplies before you receive them.

If at any time you need assistance with your bill or insurance please contact our office manager: Delia Hughes.

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) working days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as 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 grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content. I authorize Lowell Family Dentistry to release all necessary information to my insurance company for the purpose of payment, and authorize assignment of said benefits.

X_____ Date:_____ Relationship to patient:_____

Signature of patient, parent, or guardian (required for all dependent children under the age of 18)

X_____ Date:_____ Relationship to patient:_____

Signature of spouse of patient, parent, or guardian (required for all patients, and dependent children under the age of 18)