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Consent for Treatment and Financial Agreement

Consent for Treatment

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care. I agree to the use of anesthetics and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patients with Insurance

I understand that any expected payment form my insurance company is an estimate only and that I am responsible for any portion not covered by insurance. I further understand that my estimated portion must be paid in full on the day of the treatment. Any amount not covered by the insurance company is due and payable in full immediately upon notification by the insurer. It is my responsibility to verify my coverage. If payment is not completed as agreed and communication has not been made with the office, Kozica Dental will be forced to turn my account over to a collection agency. All collection charges shall be paid by me (the patient), and Kozica Dental shall not be held liable for any damage to my credit rating.

Patients without Insurance

I understand that payment is expected is expected at time of service. I further understand that any portion not paid at this time is my responsibility. If payment is not completed as agreed and communication has not been made with the office, Kozica Dental will be forced to turn my account over to a collection agency. All collection charges shall be paid by me (the patient), and Kozica Dental shall not be held liable for any damage to my credit rating.

Late Fees

For balances over 30 days, a minimum monthly finance charge of $5.00 will apply to all balances of $350.00 or less, and a monthly finance charge of 1.5% will apply to all balances over $350.00.

Cancellation Fees

It is the policy of this office to charge a fee for the time reserved for patients who miss an appointment or cancel with less than 24-hour's notice.

Print Name: _____
Patient's Signature: _____ Date: _____