PATIENT CONSENT

Clinical

1. I authorize Dr. Eversgerd and Allure Dental (The Practice) to perform all recommended treatment.

2. I authorize the Practice to take radiographs, study models, photos and other diagnostic aids or materials (collectively, “Diagnostic Material”) as needed to make a thorough diagnosis. I authorize such Diagnostic Material may be released to third party payors and/or other health professionals.

3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and I am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness and/or lack of coordination.

Financial

4. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a $10.00 billing fee will automatically be tabulated into my account if my balance is 60 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

5. A missed appointment fee will be charged to my account for all missed appointments or last minute cancellations by me. I am aware that to hold down operating costs, 48 hours’ notice of cancellation is required.

Insurance

6. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

7. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf in my name listed as “signature on file” and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.

_____
Patient’s Name (please print)

_____ _____
Signature of patient or parent/legal guardian Date