SOUTHERN SMILE STUDIO

FINANCIAL AGREEMENT

Informed Consent:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in any medical status. I authorize the dental staff to perform any necessary dental services, such as x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. Further, I understand that these photographs or images may be shown to other persons for educational or promotional purposes. I also authorize the doctor (and her employees for assistance when applicable) to perform any and all forms of treatment, medication and therapy with my informed consent in connection with my diagnosis and treatment plan.

Financial Agreement:

**Your insurance policy is a contract between you and your insurance company in which the doctor is not involved. Even though a service is “covered” by your insurance policy, this does not necessarily mean that your insurance will pay for the service. If you are unsure of your responsibility, please contact your insurance company prior to your visit. The undersigned agrees that payment of this account is guaranteed. Even though I may have dental insurance coverage, I understand payment for services rendered is my responsibility. It is my understanding that payment is due at time of service unless other financial arrangements have been made. As a courtesy, we will be glad to file your dental insurance claims. All balances after 90 days are subject to a 1.5% finance charge. Any insurance payment will be applied to the patient’s account. In case of default of payment, all collection fees, attorney fees, court costs, and any other expenses will be paid by the undersigned.

Patient Signature _____

(or Parent/Guardian if under 18)

Date_____