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 the office of any changes in my medical status. I authorize the doctor (and his/her employees for assistance when applicable) to perform and any and all forms of treatment, medication and therapy with my informed consent in connection with my diagnosis and treatment plan. I understand my responsibility for payment for services rendered is my responsibility (even though I may have insurance coverage) and that payment is due at the time of service, unless other financial arrangements have been made. I understand that all insurance quotes are only estimates based on information received from the insurance company and that those amounts are never guaranteed either by the insurance company or the dental office. I further agree that any amount that may be left outstanding on the account due to delayed or non-insurance payment 90 days following treatment will be my responsibility.

Patient Signature_____ Date_____

INFORMED CONSENT