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AUTHORIZATION & RELEASE (*CONSENT*)

I understand that my insurance contract is between my insurance company and myself; it is unique to my situation; and may have its own allowable fee schedule, deductible, waiting periods, frequency limitations, and excluded services. I understand this office will offer an estimate of insurance benefits; however due to the wide variety of insurance plans, it is only an estimate.

I am fully responsible for all charges for dental services and agree to pay my estimated portion at the time of service unless other arrangements have been made. I also agree to pay in full any balance not paid by my insurance company within ninety (90) days of the date services are rendered.

I understand a 1 $\frac{1}{2}$ % finance charge (18% APR) will be added to my account if the account becomes over ninety (90) days past due. At the discretion of the dental office, a \$50 fee will be charged if 24 hour cancellation notice is not given. A \$25 fee will be charged for all checks returned on my account from the bank. If my account should be assigned to collections, I understand there is a \$50 fee. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I have read this form and understand the information on it.

Patient/
Responsible Party (*if minor*) _____ Date _____