NEWTOWN
Family Dentistry

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I voluntarily and knowingly request and consent to the services, treatment and/or procedures recommended by the dentist and to the diagnostic methods deemed appropriate by the dentist which may include but not limited to x-rays, study models, imagery and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods.
Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatment and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatment, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with its significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all cost associated with the services, treatment, procedures and/or diagnostic methods performed and utilized by the dentist and others.
I acknowledge that any insurance coverage or managed care benefits that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or employer. The dentist is not a party to this contract and the services, treatment, procedures and/or diagnostic methods provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for services, treatment, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company or managed care company for any reason (including but not limited to the insurance company or managed care coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after billing the dentist. I acknowledge that this is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

All returned checks will be subject to a $35 return check fee. Any account balances that remain unpaid for 90days from the date of service may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection cost of a minimum of $25 and up to 30% of account balance. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all cost and reasonable attorney's fees incurred in connection within.

Appointment time will be reserved just for you. Confirmation text, e-mails or calls will be made as a courtesy however it is your responsibility to keep the appointment. Appointments that are not kept or cancelled within 24hrs or failed will incur a $75 fee that will be charged to your account.

I consent to the dentist's use and disclosure of my health information to my insurance or managed care company and any agent therefor. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and/or managed care to make payment directly to the dentist for the cost associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent therefor) or attorney to whom the unpaid account balance has been assigned to referred by mail to any address that I provide to the dental office and/or by facsimile, e-mail or phone number (whether a cell phone or landline) at any facsimile number, e-mail, address or phone number (whether cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient/Parent if minor:_____Date:_____

Print Name: _____ Date:_____