CONSENT FOR TREATMENT AND OFFICE AGREEMENTS

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my or my dependant's dental needs.

Upon such diagnosis, I authorize the doctor and/or a designated staff to perform all recommended treatment mutually agreed upon by me as required in providing proper care.

I consent to the use of any anesthetics, sedatives and other medication deemed necessary for my dental care. I fully understand that using anesthetic agents embodies certain risks.

Dentistry is a commitment for both the patient and the dental team. The following are a few guidelines, which will clarify and strengthen this commitment:

Consultation: I regularly consult with colleagues to make sure that I am doing the best work possible. When I discuss any patient under those circumstances, I withhold any identifying information to insurance confidentiality.

Appointments/Reservation Changes: By scheduling an appointment, you reserve a specific time with our office. If you need to reschedule your reserved time, we ask that you give us notice of at least 2 BUSINESS DAYS. Giving adequate notice results in avoiding a cancellation fee of $55.00 ***per hour*** for the time reserved for you.

Business Hours/Phone Contact: Our normal business hours are Monday–Thursday from 8:00 am–5:00 pm. During normal business hours, you are welcome to contact us by phone at **(707) 579-9993** or after hours at Dr. McCormick's home at **(707) 829-3907**.

FINANCIAL ACKNOWLEDGEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred for their care. Financial responsibility on the part of each patient will be determined as accurately as possible before treatment is started.

All emergency dental services or any dental services performed without previous financial arrangements must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that they are personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms and assist in making follow-up calls to the insurance companies should the need arise. Payment by the insurance company will be made directly to the patient. If, at any time, a payment is sent to the dental office, a prompt refund will be made to the patient by the dental office for any credit accrued. The dental office will not render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on any unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangement are satisfied.

Following examination, diagnosis and consultation, you will be presented with a definite treatment plan as well as any alternatives and their costs. This is not a contract, as either party may change it. Unless additional work, or changes, becomes necessary, the work will be completed as specified and for the fee quoted, provided that treatment is started within six months of the date of presentation.

In consideration of the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore that reasonable value of said service to said doctor, or his assignee, at the time said services are rendered or per any financial agreement I have made with the dentist or his assignee. I further agree that the reasonable value of said services shall be billed, unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I grant my permission to the doctor, or his assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____	_____	_____
Signature of Patient, Parent or Guardian	Date	Relationship to Patient
_____	_____	_____
Signature of Guarantor of Payment/Responsible Party	Date	Relationship to Patient