

CONSENT

1. I authorize Dr. Jamie Grider and staff to take all necessary X-RAYS, STUDY MODELS AND OTHER DIAGNOSTIC AIDS as needed to make a thorough diagnosis.
2. I authorize Dr. Jamie Grider to PERFORM ALL RECOMMENDED AND AGREED UPON TREATMENT. I also authorize the use of anesthetics (as needed) and I am fully aware that using anesthetic agents involves certain risks.
3. I AM RESPONSIBLE FOR PAYMENT for all services rendered on my behalf and my dependents. I have been informed that PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED, unless prior arrangements have been made. I am aware that a 2.0% finance charge is automatically tabulated if my account is 60 days or older. Should my account become delinquent, I will assume all additional collection costs and legal fees.
4. I understand that a BROKEN APPOINTMENT FEE will be charged to my account for all broken (no call/no show) appointments or appointments that are not cancelled/rescheduled at least 24 hours prior to the appointment time. The amount of the broken appointment fee will range from \$25.00 to \$50.00, depending upon the amount of time allotted for the missed appointment. Please be courteous and cancel in advance if you are unable to make it to your appointment. If we know in advance that you will be unable to keep your appointment, we can contact someone on the stand-by list to come in at your appointment time.

Patient/Responsible Party _____ Date _____

INSURANCE PATIENTS

I authorize Dr. Jamie Grider to submit claims for payment for services rendered or pre-authorizations if necessary to my insurance company on my behalf and in my name listed as "Signature on File," and assign to Dr. Grider the dental insurance benefits.

We are happy to file insurance claims for our patients. As a courtesy to you, we follow up on your claim for 45 days. If the claim remains outstanding after 45 days, we will then close the claim and any unpaid balance becomes your responsibility. Should you need any documentation from our office in your correspondence with the insurance company, we will be glad to provide it for you.

I understand that insurance coverage is only an estimation. I understand that I am responsible for the cost of all treatment not covered by my insurance.

Patient/Responsible Party _____ Date _____

TURN OVER TO COMPLETE