



Consent for Services

As a condition of treatment by Anderson Smile Studio, financial arrangements must be made in advance. Financial responsibility of each patient must be determined prior to treatment commencing.

Patients with dental insurance need to understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all services rendered. Anderson Smile Studio will help prepare each patient's insurance forms or assist in making collections from insurance companies and will credit all collections to the proper patient's account. However, Anderson Smile Studio cannot 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) will be charged on all unpaid balances exceeding 30 days, unless previous financial arrangements have been made.

I understand that any fee estimate for dental care can only be extended for a period of six months from the date of initial presentation and are estimates only. All estimates are based on the information provided by your insurance company and are only as accurate as that information.

In consideration for the professional services rendered to me by Anderson Smile Studio, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to by me, in writing, within the time payment is due. I further agree that a waiver of any breach 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 a suit is instituted hereunder.

I grant my permission to Anderson Smile Studio to telephone me to discuss this statement or my treatment.

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

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to Patient : _____