CONSENT

1. I authorize Legacy Family Dental and team to take all necessary **X-RAYS, STUDY MODELS AND OTHER DIAGNOSTIC AIDS** as needed to make a thorough diagnosis.
2. I authorize Legacy Family Dental 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 the **PAYMENT IS DUE, IN FULL, AT THE TIMES SERVICES ARE RENDERED**, unless prior arrangements have been made. I am aware that should my account become delinquent, I will assume all collection costs, legal fees and a 4.0% finance charge accruing from the date at which the account became 90 days past due.
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 or rescheduled at least 24 hours prior to the appointment time. The fee can range from $25.00 to $50.00, depending upon the amount of time that was reserved. **PLEASE BE COURTEOUS** and let us know in advance if you are unable to keep your reserved time.

Patient/Responsible Party:________________________________ Date:____________

INSURANCE PATIENTS

I authorize Legacy Family Dental to submit claims for payment for services rendered or pre-authorizations, if necessary, to my insurance company on my behalf. I authorize dental insurance payment to be assigned to Legacy Family Dental/Dr. Jamie A. Grider.

We are happy to file insurance claims for our patients. As a courtesy to you, we follow up on your claim for 90 days. If the claim remains outstanding after 90 days, we may then close that claim and any unpaid balance becomes your responsibility.

I understand that insurance coverage is only an estimation based upon information given to Legacy Family Dental by my insurance company. I understand that I am responsible for all costs of treatment should my insurance not pay what was expected.

Patient/Responsible Party:________________________________ Date:____________