Carol A.Horkowitz, D.M.D. P.A.

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Consent for Treatment

Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

This to verify that I, the undersigned, hereby authorize Dr Carol A. Horkowitz or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by Dr. Carol A. Horkowitz to make a thorough diagnosis.

Upon such diagnosis, I authorize Dr Carol A. Horkowitz to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care, and to the use of local anesthetic as indicated.

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

Signature _____ **Date** _____

Authorization & Release

I certify that I have read and understand the above to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Carol A. Horkowitz or her representative to use or release any oral,written, or electronic health records for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

I understand that payment is due on the day services are rendered. In the case of larger procedures in which multiple appointments are necessary, I understand that 50% of the total is due at the beginning of treatment and the remainder is due upon completion unless oher payment arrangements have been made.

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

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

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.
In consideration for the professional services rendered to me by this practice, 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 if dissatisfied with prosthesis and it is returned, I will be responsible for reasonable and customary fees for procedures, courier and lab fees incurred to fabricate the prosthesis.

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 be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

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

Signature _____ **Date** _____

Relationship to Patient: _____

Response Date: ____/____/_____