Burgess Dental
Dr. Bill Burgess ~ Dr. Louis Burgess

Consent for Medical Treatment ~ Release of Information ~ Financial Responsibility

Please initial **each section**:

Consent for Dental Care Services: I authorize consent for dental treatment at Burgess Dental Office. _____

Authorization for Release of Information: Burgess Dental Office may release information from my dental records to any health care provider involved in my care and treatment. Burgess Dental Office may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of dental records information to an insurance company or other payer pursuant to this authorization, Burgess Dental Office, is no longer responsible for the confidentiality of any information known or possessed by the payer. _____

Financial Agreement: I understand I am responsible for the payment and/co-payment that is due at the time of service. I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Burgess Dental Office which are not paid by my dental insurance or other payer. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the responsible party and address on file with Burgess Dental Office. I understand that I am responsible for a $30.00 returned check fee in addition to any other associated bank charges. _____

Payment Options for Your Convenience:
(1) A 5% discount for payment in full at time of treatment with cash or check.
(2) We accept Visa, MasterCard or Discover
(3) 3, 6, or 12 month payment plan upon approved credit through Care Credit. These are non-interest bearing accounts.

No Show/Cancellation Policy: I understand that I will be charged a $50.00 fee for appointments that are missed/broken. We ask that you cancel/reschedule 24 hours prior to the scheduled appointment. I also understand that I will be responsible for this charge and that my insurance company will not pay for the cancellation/broken appointment fees. _____

_____
Signature of Patient or Responsible Party

_____
Date