TREATMENT AND FINANCIAL CONSENT
EDISON PROSTHODONTICS
1941 OAK TREE ROAD, #301
EDISON, NJ 08820
732 906 0077

- I hereby authorize the doctor or designated staff to take X-rays, diagnostic scans/ impressions, photographs and other diagnostic deemed appropriate by by the doctor to make a thorough diagnosis of my dental needs.
- Upon such diagnosis, I authorize the doctor to perform recommended treatment mutually agreed upon by me and employ such assistance as required to provide proper care. I understand that I can ask for complete recital of risk and benefits of any treatment rendered.
- I agree to the use of anesthetics and other medications necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for complete recital of any possible complications.
- I agree to be responsible for payment of all services rendered on my behalf, my spouse or my dependents. I understand that payment is due at the time of service unless other arrangements have been made in writing and are signed by this office and the parent/responsible party. If the office doesn't receive payment at the time of service and there is arrangements made in writing, I understand that interest will begin to accrue on my remaining balance on my account 30 days after the date of service the rate of 1.5% per month (18% per annum). I understand that interest will continue to accrue at this rate until the remains balance is paid in full.I also understand that any account is placed with an attorney or collection agency because of any unpaid balance, I hereby agree and promise to pay one time collection fee of $100.00 or 30% of any unpaid balance on my account at the time of placement with attorney or collection agency, whichever is greater.
- For those patients who are covered by insurance, we will accept assignment of benefits as a courtesy. Most dental insurance plans don't cover 100% of the cost of your dental treatment. Because of extreme delay in receiving payments from insurance companies, you will be asked to pay your deductible and a portion of of the changes the day the services are rendered. We will ESTIMATE the coverage as closely as possible, but until we actually receive the payment from the insurance company, it is just an ESTIMATE.
- A $30.00 service fee will be charged for any returned checks.
- We take much pride in the fact that majority of the time our patients don't have to wait in the waiting room. We believe your time is as valuable as ours. If an appointment is cancelled without 24 hours prior notice or a patient doesn't show for an appointment, a #75.00 fee will be charged.

Name: _____

Sign: _____ Date:_____