Beverly Claiborne, DDS

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CONSENT TO EXAMINATION

I give my consent to a dental examination. I understand that I may need x-rays, study models, photographs, and/or any other diagnostic procedures the doctor deems necessary in order to accurately access my oral condition and make a thorough diagnosis of my dental conditions and needs.

Initial Here_____

ACKNOWLEDGEMENT OF PATIENT RESPOSIBILITY FOR PAYMENT

I understand that I am fully responsible for payment of all charges, including any amount not covered by insurance. I understand that the office will provide an estimate for recommended services and that it is based on information provided by my insurance carrier by phone and is in no way a guarantee of payment. I understand that the office has no control over policy limitations and/or changes in eligibility or coverage. Some procedures may be exempt from coverage regardless of need. **I understand that payment of my estimated portion is due at the time of service.** I understand that in the event that a balance is generated on the account, it will be subject to a 1.5% monthly late fee. I understand that if it becomes necessary to refer the account to collection services, a $100.00 service fee will be applied and I will then be liable for all legal fees.

Initial Here_____

ACKNOWLEDGEMENT OF 24 HOUR NOTICE POLICY

I understand that it is the office policy to **require at least 24 hours notice** for any appointment cancellations or rescheduling. I understand that any changes I make to my scheduled appointment with less than 24 hours notice will be subject to **a charge of $50 per hour of scheduled time.** I further understand that if I am late 10 minutes or more to my appointment, it may be necessary to be reschedule.

Initial Here_____

MY FULL SIGNATURE BELOW CONFIRMS THAT I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THESE POLICIES.

Full Signature _____ **Date** _____