Consent for Treatment

1. I hereby authorize Dr. Michael J. Morris or any of his staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Morris to make a thorough diagnosis of (name of patient) _____ dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risk. I understand that I can ask for a complete recital of any possible complications.

Financial Policy

Thank you for choosing our office for your dental needs. We are committed to providing you with the highest quality dental, and payment of your bill is part of successful treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, NOT with your insurance company. Your insurance policy is a contract between you, your employer and the insurance company. We are considered an **OUT OF NETWORK** provider. Dr. Michael J. Morris is not a party to that contract. Our obligation is to provide excellent dental treatment to all our patients. Our fees reflect our commitment to the quality and service you deserve, regardless of any insurance company's determination. As a service to our patients, we will prepare & submit your insurance claim form if **all insurance information** is provided to us. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

ALL CO-PAYMENTS ARE DUE AT THE TIME SERVICE IS PROVIDED. Our office accepts cash, personal checks, money orders, or any major credit card. Outside financing is available through CareCredit upon request and approval. If you have any questions concerning your estimated co-pay and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

I understand that insurance benefits are an **estimate only**. I agree to be responsible for payment of all services & materials not paid by my dental insurance for myself or my dependents.

There will be a **$35.00** service charge on all **returned checks**. Any **UNPAID BALANCE** older than **60 days** will be subject to a **monthly interest of 1.5%.** Accounts with balances over 90 days without prior financial arrangements will be considered delinquent and the patient will be responsible for payment of collection, attorney fees, and court costs associated with the recovery of the monies due on the account.

We make every effort to honor your reserved time and ask that you extend the same courtesy to us. There is a notice of **cancelation 48 hours in advance** (2 business days); you will be charged **$50** otherwise. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

_____
Print Name

_____ _____
Signature of Patient/Legal Guardian Date