Lakeside Endodontics, P.A.

CONSENT FOR SERVICES AND PAYMENT ARRANGEMENTS

PATIENTS WITHOUT DENTAL INSURANCE:

I understand that all responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a finance charge and billing charge may be added to my account, after 30 days and in addition to any collection charges.

All emergency dental services, or any dental services performed without previous financial arrangements, **must be paid** for in cash, check or credit card, **at the time services are performed.**

PATIENTS WHO CARRY DENTAL INSURANCE:

Patient understands that they assign their insurance benefits to LAKESIDE ENDODONTICS, P.A. Furthermore, understand that this form is valid for one year unless the patient cancels the authorization through written notice to the healthcare provider (LAKESIDE ENDODONTICS, PA.). Patient also understands that they are responsible for the portion that they are obligated under their insurance policy to be paid at today's appointment unless prior arrangements have been made.

Patient understands that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

Patient grants permission to LAKESIDE ENDODONTICS,P.A. or their assignee, to telephone patient at home or at their place of employment discuss matters related to this form.

____ **NO INSURANCE**-If you are not covered by any insurance ***your bill is due when services are rendered.*** For your convenience we do accept all major credit cards.

____ **SINGLE INSURANCE**-If you are covered by 1 insurance plan ***your estimated co-payment is due when services are rendered.***

____ **DOUBLE INSURANCE**-If you are covered by 2 or more insurance plans, ***a co-payment may still apply.***

I have read the above conditions of treatment and payment and agree to their content.

_____ _____ _____

Signature of patient, parent or guardian Guarantor of payment/responsible party | Date | Relationship to Patient