Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs. (We will inform you of the need for these and receive a verbal agreement.)
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by the doctor and me.
3. Charges incurred at Frankart Family Dental for dental services, including insurance co-pays and deductibles, are due and payable at the time services are rendered. We do accept assignment of dental benefits. However, dental insurance is an agreement between you and your insurance company – you are ultimately responsible for payment of your bill regardless of the amount covered by your insurance. Accounts which are 90 days past due from the date of treatment will be charged a monthly fee of 1.5%. An additional processing fee of $250.00 will be charged if an account is turned over for collection. There will be a charge of $30.00 for any returned non-sufficient funds check.

   My payments will be made by:

   ☐ Cash (5% discount if paid in full) ☐ Check (5% discount if paid in full)

   ☐ Credit Card ☐ Care Credit

4. I also understand that my health information will be used and communicated for the sole purposes of providing treatment, obtaining payment, and conducting health care operations. Health information will not be used for other purposes unless having asked for and voluntarily given written permission.

Patient or Guardian Printed Name _____

Signature _____Date_____