Dental Services Agreement

Consent for Treatment
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 Patient's dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by Patient, Patient's Guardian or Legal Representative and Doctor and to employ such assistance as required to provide the necessary and proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I am either aware of these risks or understand that I may ask for a complete recital and disclosure of these risks.

Authorization to Release Information
To the extent permitted by law, I consent to the use and disclosure of my protected health information to carry out payment activities in connection with any and all claims.

Communication
By completing this section, you are giving Dr. Chad Engelbrecht or designated staff, d.b.a. Engelbrecht Family Dental, PA, permission to leave your scheduling, medical and billing information on the answering machine/voicemail/email you provide and/or with the person you state below.

I authorize Engelbrecht Family Dental, PA to leave scheduling, medical and billing information on the following means of communication.

Phone numbers already provided: (please circle) Yes No

email address: _____

I authorize Engelbrecht Family Dental to review information with the following person:

_____

(First and Last Name) (Relationship to Patient)

Assignment of Benefits
I hereby authorize and direct payment of dental benefits otherwise payable to me, directly to Engelbrecht Family Dental.

Agreement to Pay and Financial Policy
DENTAL BENEFITS
• We are pleased that many of you have Dental Benefit Plans and our office will attempt to assist you in obtaining the maximum benefits provided for in your benefit plan. However, not all services are a covered benefit in all contracts. Some insurance carriers and employers select only some services to be covered. You are responsible for payment of all services regardless of the payable benefit. You agree to be responsible for all charges for dental services and materials not paid by your dental plan. You should contact your insurance carrier and/or your employer's benefits coordinator for assistance in understanding your plan.

• By signing this Agreement, you agree and understand that we may conduct ongoing checks of your credit history by obtaining a consumer credit report from a consumer credit reporting agency. You agree that we may furnish information about your account to the credit bureau. You are hereby notified that a negative credit report reflecting on your credit record may be submitted to a credit reporting agency if you fail to fulfill terms of your payment obligations as set forth in this Agreement.

AGED ACCOUNTS
• Balances older than 60 days may be subject to a late fee of $10.00 per month and an interest charge of 8.00% annually. These additional fees and interest charges may be applied to any balances remaining unpaid at the end of the second month.

• In the event we must incur collection costs or attorney fees in connection with your account, you agree to pay the costs of collection, including, but not limited to, court costs and reasonable attorney fees.

Ongoing Signature on File
I understand and authorize that this form remains in effect provided that I am a patient of record with Engelbrecht Family Dental, PA.

PRINT NAME OF PATIENT: _____

SIGNATURE: _____
Patient or Patient's Parent, Guardian or Legal Representative

_____
SIGNATURE OF FINANCIALLY RESPONSIBLE (if other than patient):

PRINT NAME OF PATIENT'S REPRESENTATIVE: _____

DATED: _____