River Pointe Dental

Rachelle D. Hardy, DDS, PC & River Pointe Dental of Huntley, LLC

Doctor: ________________________________

CONSENT TO TREATMENT

Patient: ________________________________ SS # ___________________________
Please Print | Parent or Guardian if Patient is a minor

Consent to Treatment: I hereby authorize and request the above named doctor(s) to provide me with dental treatment. This authorization shall also include any and all surgical procedures, which include the removal of hard and soft tissue or the correction thereof, after the procedure has been fully described, and to do whatever procedures that his/her judgment may dictate during the treatment with my consent. I authorize and request the administration of such anesthetic or anesthetics as may be deemed advisable by the doctor. It has been explained to me, and I understand, that a perfect result is not guaranteed or warranted, and that any limitations will be described to me at the time of the procedure.

Release of Information: You are authorized to release any information you deem appropriate concerning my dental condition to my insurance company, attorney, adjuster, or any other person necessary for you to process any claim for reimbursement of charges incurred by me at your office. (Please refer to our Notice Of Privacy Practice).

Right to Receive Payment: I authorize and assign to you, the dental provider, the right to receive direct payment from my attorney, insurance company, or any other party who may be obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled.

Account Obligation: I understand that I shall continue to remain responsible for any uncollected or unpaid balance on my account. I also understand that I am responsible for any deductibles and co-payment established by my insurance company. I agree to send any insurance payment I receive for dental services performed in this office to Rachelle D. Hardy, DDS, PC or River Pointe Dental of Huntley, LLC unless services are paid for in full at the time of treatment.

I understand that I will be charged 25% of my balance for any account turned over to collection and 50% of my balance if my account is turned over to an attorney for legal purposes. I understand that a monthly $10.00 processing fee and/or finance charges will applied to my account for any unpaid balance over 90 days, regardless of any pending insurance, workers' compensation or legal claims.

_______________________________________ ____________________________
Patient Signature (parent or guarding if minor) | Date

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