NORWICH FAMILY & COSMETIC DENTISTRY
RESPONSIBILITY AND CONSENT STATEMENT

I hereby authorize and request the performance of dental services for myself or for

NAME:_____ AGE:_____

I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment.

I understand and acknowledge that I am **financially responsible** for the services provided for myself or the above named regardless of the insurance coverage.

SIGNATURE OF RESPONSIBLE PARTY

RELATIONSHIP TO ABOVE PATIENT

Our office prides itself on quality care. If you have any questions regarding the information on this paper, please speak to our office manager.

1. **To keep your appointment and to show up on time.**
   If you are unable to keep your appointment, we require notice at least **(24) twenty-four hours** in advance. If you do not notify us in advance, and you fail to appear for an appointment or if you arrive more that 10 minutes late to an appointment, you agree that we may charge your account a fee of **($40.00) forty dollars** for the missed/late appointment.

2. **To pay your bill promptly.**
   A valuable service is being performed at your request and we expect payment for these services at the end of your scheduled appointment. You agree, therefore, that you will pay for these services performed on you and or your family member at the time of the visit. We will file insurance for you, however that does not excuse your portion of the **co-pays or deductibles** for that date of service. If you do not pay the bill or make satisfactory payment arrangements, you agree interest may be charged at the rate of 1 1/2 % per month, 18% per year. After (90) days we may refer this matter to an attorney or a collection agency.

3. **Regarding your insurance coverage.**
   Our office participates with several insurance companies, however, it is your responsibility to know your policy. Co-payments and deductibles are due the day of treatment. We will submit pre-estimates for you. Ultimately any additional cost is the patient's responsibility. There will be a $20.00 return check charge for any checks returned to our office for insufficient funds.

PATIENT OR PARENT OF PATIENT IF PATIENT IS UNDER AGE 18

DATE