Kind Smiles DENTAL

GENERAL DENTISTRY FOR CHILDREN AND YOUNG ADULTS

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____, and assign
Name of insurance company(ies)
directly to Kinder Smiles Dental P.C. all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date: _____ Signature: _____
Signature of Patient/Guardian

Patient Agreement and Financial Policy

I hereby agree to be responsible for the costs of care provided by Dr. Fogel and/or the dental team for myself or my dependant(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, maximums and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor I am responsible for the total amount(s).

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 24 hours prior to my scheduled appointment time. **For any missed appointment a fee of thirty-five ($35) dollars will be assessed to my account for every fifteen minutes scheduled.** This fee covers the cost of office overhead during time set aside specifically for me or for my dependent(s).

We make every effort to schedule appointments that are the most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that for any treatment less than five hundred ($500) dollars payment in full is due at the time of service. Any payment plans* I agree to with this office must be completed. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney I agree to pay all collection and attorney fees.

*An 18% (eighteen percent) per annum finance charge is assessed to any account that is more than thirty days old.

Date: _____ Signature: _____
Signature of Patient/Guardian

MINOR/CHILD CONSENT

I, being the parent or guardian of _____, do hereby request and
Name of minor/child
authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date: _____ Signature: _____

Signature of Patient/Guardian