<u>Consent for Services</u>

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All claims are filed directly to your insurance company by our office. If your insurance is out of network with us, you may receive a bill for the amount that your insurance did not cover.

DELINQUENT ACCOUNTS will be referred for collections after 30 days and subject to credit reporting. You will be responsible for the collection fees/attorney fees.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian: _______________________
Date: ____________________
Relationship to Patient: ____________________

<u>Authorization</u>

Initials
____1. I hereby authorize the release of any information relating to insurance claims and I authorize payment of my group insurance benefits directly to Dr. Tony Reyes D.D.S. c/o Eldorado Dental.

____2. I understand that my insurance co. may pay less than the actual bill for services and that I am fully responsible for payment ofmy account.

____3. I give consent to Dr. Tony Reyes D.D.S. to perform necessary procedures to diagnose, treat and care for the dental needs for my child and/or myself.

____4. Parent or legal guardian must be present for dental visits of children under the age of 18.

____5. In order to give your child our full attention we request that you remain in the reception area.

____6. If your child is not cooperative we may suggest referral to a pediatric specialist. However, you will be charged an office visit fee for the time spent with your child.

I certify that the information I have provided here is accurate

Signature:____
Date: _______ / _______ / _______