Kenneth L. Egger, DDS, P.C.

PATIENT AUTHORIZATION AND CONSENT FORM

Please sign and date all sections that apply. You will receive a copy for your records.

Consent of Treatment: The undersigned hereby authorities Dr. Kenneth L. Egger, Jr. to take x-rays, study models. Photographs or any other diagnostic aids deemed appropriate by Dr. Egger to make thorough diagnosis of the patient's dental needs. I also authorize Dr. Egger to perform any and all forms of treatment, medication and therapy that may be indicated for my dependent or myself. I further authorize and consent that Dr. Egger choose and employ such assistance, as he deems fit. I also understand that the use of anesthetic agents embodies a certain risk.

Signature of Patient or Responsible Party: _____Date: _____

Dependent Consent: I authorize Dr. Kenneth L. Egger, Jr. to perform any necessary dental treatment for _____, my Son, Daughter, Legal Dependent (circle one). I also authorize the use of Nitrous Oxide Gas for Analgesia, as indicated for the treatment of my minor Dependent.

Signature of Patient or Responsible Party: _____Date: _____

Insurance Assignment and Release: I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dr. Kenneth L. Egger, Jr. all insurance 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 Dr. Egger to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:_____Date:_____

Financial Terms, Conditions and Consent: I understand that responsibility for payment of dental services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered unless other arrangements have been previously made. If the insurance payment goes directly to you, the charge must be paid to us at time of service. All emergency treatment will be rendered on a cash basis. Treatment involving laboratory fees, such as crowns, bridges, partials, dentures, etc. will be paid in this manner; One-half due at the first appointment and the remaining one-half due when the appliance is placed into the mouth. Other methods of payment accepted include: Cash; Checks; CareCredit and all major Credit Cards.

I further understand that a $5.00 rebilling fee will be added to any account balance that is thirty days old. A monthly statement will be sent to any Responsible party carrying a balance. I further understand that broken appointments or appointments cancelled with less than 24 hours notice nay be subject to a broken appointment fee of at least $25.00. I (we) promise to pay such collection costs and reasonable attorney fees as may be required to effort collection of the balance, should a default on this note occur.

Patient Signature:_____ Date:_____

Parent or Responsible Party: _____ Relationship to Patient: _____