

**PARENTAL
CONSENT FORM**

PHONE: (281) 239-3900
FAX: (281) 239-3848



PARENTAL CONSENT

(For Children under the age of 18 years)

I, _____
(Parent or Guardian)

Hereby give my consent for _____

to have his/her dental treatment completed. I fully understand the work being done and the total cost of treatment. I also understand that I will be notified if any further treatment is indicated, and I agree to be responsible for the charges. I also agree that I understand that the parent/legal guardian (proof must be supplied) must remain in the office while exams and/or treatment is being performed.

(Signature of Parent or Guardian)

(Date)

FINANCIAL POLICY

Thank You for choosing **SMILESMART** as your dental provider. We are committed to quality Dental Care and we want you to fully understand our financial policy prior to treatment.

Full payment of all charges is due at time of service, unless arrangements has been made

- We accept most insurance benefits. **YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE HAVE NO CONTROL OVER THEIR DECISIONS AND PAYMENT OF YOUR TREATMENT.**
 - We will attempt to verify your insurance coverage and estimated your deductibles and co-payment due at time of service. Your insurance company will not guarantee payment over the telephone. Exact payment will be known after they respond to the claim.
 - We accept assignment of insurance benefits after verification of coverage for insurance payment to us.
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 - **PLEASE BE AWARE THAT YOU ARE RESPONSIBLE FOR PAYMENT OF YOUR BILL REGARDLESS OF WHAT YOUR INSURANCE DECIDES TO PAY.**
 - **If the claim checks are sent to you, you are responsible to bring the checks to our office.**
 - Once Insurance payment is received on your claim, we will bill you for any balance remaining in your account that is not paid by your insurance.

We will need payment on your account within **45 days**. Payment by check, credit card, cash or payment plan is accepted. There will be **\$25** charge for bounced check.

DELINQUENT ACCOUNTS (45 days or older) ARE SUBJECT TO REASONABLE SERVICE CHARGE AND/OR LEGAL INTEREST RATES

Please be advised that Outstanding account will be turn over to a Collection Agency. **You will be responsible for payment of any collection costs and/or attorney fees, in addition to the balance owed.** Any account that undergoes collect agency or attorney procedures forfeits any past special fees and/ or discounts, writeoffs. Any special fees, discounts, writeoff will be reversed and you will be responsible for payment of our standard fees for procedures at time of service.

When a dental appointment is made, the time is specifically reserved for you, please show up.

Missed appointments without 48 hours notification in advance is subject to \$25 charge.

I have read and understand the above financial Policy. By signing below, I acknowledge responsibility and agree to the terms as written above.

Signature of Responsible Party

Print Name of Responsible Party

Date

Patient Name: _____

