John K. Sudick, D. D. S.
13318 Bailey St. Whittier, CA 90601

Name:
Address:

Consent for Services, Financial Responsibility, Release of Health Info and Assignment of Benefits

Consent: I voluntarily and knowingly request and consent to the services, treatments, and /or procedures recommended by the dentist for myself or my dependent minors, and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to x-rays, study models, diagnostic photos or imagery, and other aids. I authorize the dentist to perform all such services, treatments, and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments, and /or procedures and in utilizing such diagnostic methods. I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures, and /or diagnostic methods that have been recommended.

Financial Responsibility: My signature on this form indicates that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures, and/or diagnostic methods performed and utilized by the dentist and others for my dental care and the dental care of my spouse and dependents. I also understand the limitations of dental insurance and that any estimates of benefits given are just that, an estimate and that ultimately, I am responsible for the fees set forth and discussed in the treatment for myself and my dependents regardless of insurance benefits promised by my insurance carrier. I acknowledge that any insurance coverage or benefit that I may have is based on a contract between my insurance company and me, my spouse and /or my employer. The dentist is not a party to this contract, and the services, treatments, procedures and /or diagnostic methods are provided to me and my dependents. As a courtesy to me, the dental office will bill my insurance company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance coverage information and any changes thereto.

I understand that all responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered. If insurance benefits have been estimated, I understand that any insurance charges and co-payments are my responsibility at the time care is provided. Charges and fees will increase slightly each year. All returned checks will be subject to a $47 return check fee. Any account balances that remain unpaid for 60 days from the date of service shall accrue interest at the rate of 1 ½% per month or 18% per year and may be referred to a collection company or attorney. In the event this occurs, I understand and acknowledge that I will be liable for a collection and credit reporting fee of $90 to cover initial costs of both outside services as well as our own to collect on your account. In addition, I will be responsible for any court fees required for collection purposes. Further, in event any unpaid account balance is sent referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

Disclosure of Health Info and Assignment of Benefit: I consent to the dentist's use and disclosure of my health information to my insurance company and any agent thereof. I hereby assign to the dentist all of the insurance benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me or my dependents and I authorize my insurance company to make payment directly to the dentist for the costs associated therewith.

Communication Consent: I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agency thereof) or attorney to whom an unpaid account balance has been assigned or referred by various communication methods including by not exclusive of mail at any address that I provide to the dental office and/or facsimile, email, or phone (either by cell phone or landline whether by method of voice or texting) that I provide to the dental office or any agent of the dental office.

Late Cancellation Policy: I understand the late cancellation policy at your office. Since the staff do not double book the doctors or hygienists time, patients who cancel less than 24 hours in advance (not including weekends or holidays), or do not show for an appointment, are charged a late cancellation fee of **$107.00 per 30 minutes of appointment scheduled.** We would be glad to reschedule your appointment at a more convenient time if you allow us 24-48 hours notice.

Responsible Party Signature: _____ **Date:**

Print Name: **Circle:** Patient or Guardian

Revised 01022018