**Consent for Services**

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 emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

**In regard to release of information:**

I authorize the dentist and staff to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners. I authorize and request payment directly to Michael S. McKay, DMD, or his successors or assigns.

**In regard to dental treatment and insurance:**

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office is not responsible to know the limits of your dental contract and cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding ninety (90) days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of three (3) months from the date of last examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within thirty(30) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree if my account becomes past due I agree to pay all costs of collection, including reasonable attorney fees if suit be instituted hereunder.

**In regard to broken or cancelled appointments: I understand and agree to the following:**

I understand that a specific time was set aside for my scheduled appointment. Accordingly I agree to show up for my appointments. If for any reason I fail to show up or cancel my dental appointment without giving a reasonable time I will be charged.

If I must cancel or reschedule, I agree to give twenty-four (24) hours notice or a minimum of five (5) business hours.

(Hours Mon, Wed, Thur, Fri. 8:00 am — 5pm & Tues. 8:00am — 6:00 pm) If I fail to do so I agree to pay a fee of a minimum of at least $50.00 for each broken or canceled appointment.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

_____ Date:_____ Relationship to Patient: _____

Signature of responsible party, parent or guardian