Jordan Dentistry

Payment Responsibilities

- As a service to our patients, we will file your primary insurance. Acceptance of insurance payment does not release patient from any financial obligations.
- I agree that if my insurance company does not make payment within 60 days of service that I am responsible for the fees and will take up the matter with my insurance company.
- If no insurance is provided, I understand that all fees for services rendered are due and payable at the time of my and/or my dependent(s) visit. I agree as a parent/guardian, I am responsible for all fees and services rendered for the treatment of my dependants.
- **ANY CANCELLATION WITHOUT 24 HOUR NOTICE CAN RESULT IN A $75.00 CHARGE.**
- In the event that I default on my account, I further agree to pay all costs of collection.
- Emergency patients are expected to pay for services rendered at time of treatment.

Consent for Treatment

- I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
- Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risk. I understand that I can ask for a complete recital of any possible complications.

Signature_____Date_____