



## CONSENT FOR SERVICES

Thank you for choosing our office to serve your dental needs. In order to serve you best, we will evaluate each tooth in your mouth thoroughly and completely. We want you to be aware of what you need, why you need it and the fees associated with that treatment. We are confident you'll enjoy our office.

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.

Patients who carry dental insurance are responsible for payment of all dental services. All time of service, our office will research your insurance benefits and provide an estimate of the amount your plan will cover. At time of service, your estimated patient portion will be due. We will prepare and submit your insurance forms, and assist in making collections from insurance companies. All such collections will be credited to your account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Any portion that is not paid by insurance after 90 days will be the responsibility of the patient.

- I authorize my insurance company to remit reimbursements directly to Sonoran Hills Dental.
- 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.
- I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient examination.
- I grant my permission to your or your assignee, to telephone me at my home or work to discuss matters related to this form.

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

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Signature of Patient (or Parent/Guardian if patient is a minor)