Welcome to **Miles Of Smiles**, we are pleased you have chosen our practice for your dental care. We are committed to providing you with the highest quality service available. Please read, acknowledge, initial and sign all of the statements below regarding our policies and authorizations.

Consent for Treatment

I authorizes the Doctor to take radiographs, study models, photographs, and or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs.

I authorize any of the Doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me.

I understand that treatment plans are only an estimate and subject to modification depending on circumstances that may arise during the course of treatment.

I understand the use of anesthetic agents embodies a certain risk.

Initials:_____

Financial Policy Statement

I understand that all co-payments, co-insurance and deductibles are due and payable at time of service.

I understand that payment plans are not accepted.

I understand that any failure to provide necessary current accurate billing information will result in all charges for services being the sole responsibility of the patient/ responsible party.

I understand that I am expected to understand my insurance benefits, coverage and financial responsibility.

I understand that if Miles of Smiles does not have a contract obligation with my insurance company, I am responsible for 100% of the payment at the time of service.

I will be responsible for any balances not covered by my insurance.

I understand that Miles Of Smiles requires 24 hour notice if I am unable to keep any appointments. I understand that my account will be automatically billed $50.00 for missed time reserved and that I will be responsible for these charges.

I understand that a return check fee of $50 will be assessed if any check payment is returned by my bank.

I understand that any balances 60 days overdue will be charged a 1.5% per month finance charge.

I understand that any balance over 90 days may be sent to a third party collector.

I understand that should my account be sent to a third party collector, I will be charged an additional 30% of the outstanding balance or $50, whichever is greater.

Initials:_____

Patient Authorization

I hereby authorize Miles Of Smiles to apply for benefits on my behalf for services rendered.

I request that payments from my insurance company be made directly to Miles Of Smiles.

I certify that the information I have provided on this form is correct.

I authorize the release of any necessary information for this or any related claim to my insurance carrier.

Initials:____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have been provided an opportunity to review the Notice of Privacy Practices and have been offered a copy if I so choose to receive one.

Initials:_____

Name of Patient or Guardian:_____

Signature:_____

Birthdate: _____ Date:_____