PATIENT CONSENT FORM

CONSENT TO TREATMENT: Knowing that I have a condition requiring dental care, I voluntarily consent to such care, including diagnostic procedures and dental treatment ordered. I am aware that the practice of dentistry and surgery is not an exact science, and I acknowledge that no guarantee have been made to me as to the results of treatments examinations.

ACCIDENTAL EXPOSURE OF HEALTHCARE WORKER: I understand that, if a worker is accidentally exposed to my blood or other bodily fluids, I will be tested for Hepatitis B, Hepatitis C, or HIV/AIDS without my specific consent. Test results will be kept confidential to the extent allowed by the law.

FINANCIAL RESPONSIBILITY: In return for the services rendered to me at the WESTHEIMER LAKES DENTAL facility, I promise to pay WESTHEIMER LAKES DENTAL in accordance with bills or invoices presented. I understand that WESTHEIMER LAKES DENTAL will bill and collect for their services.

ASSIGNMENT OF BENEFITS: I hereby assign to the designated dentist or facility payment of dental benefits otherwise payable to me. This authorization is valid for any and all insurance claims filed on behalf of the designated facility and/or dentist. This authorization is valid until the dentist or facility has received written notice of cancellation.

In consideration for WESTHEIMER LAKES DENTAL services rendered to me, I agree to pay the charges not covered by an insured or Third-Party Payer including any deductible or co-payments or any charges not covered. Should my account be referred for collection or becomes delinquent for any reason I agree to pay WESTHEIMER LAKES DENTAL reasonable attorney fees, and collection expenses.

I agree to immediately remit to WESTHEIMER LAKES DENTAL any payments that I receive directly from any source for the service provided to me. A copy of this form is valid as the original.

To avoid any misunderstandings regarding your dental insurance, we wish our patients to know that all **professional services rendered are charged to the patient and that patients are personally responsible for payment of fees**. **If nonpayment occurs patient will be responsible for charges incurred to report to collections.** We do not render services on the basis that the insurance companies will pay our fees. We will assist you in filing all insurance claims, if the claim is not paid in 90 days, you are responsible for payment in full. **Payment is due when services are rendered unless other arrangements have been made.** If you must change a scheduled appointment, we ask that a 48 hour notice is given, otherwise a $60 short notice fee will be charged.

Signature of Patient (or Patient's Representative) Date