American Dental Care
105 N. Virginia Ave. Ste. 103
Falls Church, VA 22046

Consent for Services

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of 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 understand that the treatment plan and associated fees are only an estimate and are subject to change depending upon individual circumstances. Due to the progressive nature of dental disease, a new examination and treatment plan may be needed after a period of twelve months from the date of the original patient examination.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due in full at the time of service. I also understand that American Dental Care will submit claims on my behalf to my insurance company. However, I am solely responsible for any services rendered to me. Outstanding balances are subject to a 5% monthly APR and a $10 monthly late fee. I understand that I will have to pay for any and all court and attorney fees that result from a court case arising from my failure to pay for dental services in a timely manner as well as all collection fees, as determined by this dental office. I further understand that a $ 50.00 broken appointment fee will apply if I fail to give 24-hours advance notice to reschedule and appointment for any dependants or myself. In addition, I understand that any request for duplicated x-rays or charts is subject to a $20.00 service fee.

In the unlikely event that your check is returned for insufficient or held funds, we will debit your checking account electronically for the face amount of the check PLUS the state-authorized fee of $50. This policy allows us to resolve the problem with out reporting you to a credit bureau and harming your credit rating. The transaction will appear on you bank statement, and no one will have to contact you about payment.

There is very limited space in our operatory we want all of our patients to be comfortable and have the privacy that they deserve while receiving treatment, therefore, **only patients** are allowed in the operatory! It is absolutely imperative that all minors be accompanied by a parent or legal guardian to each appointment.

We allow a 15 minute grace time for all appointments. If you are more than 15 minutes late to your appointment it is at the office's discretion as to whether or not you will need to reschedule your appointment.

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

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Signature of patient, parent or Guardian Date:_____

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Relationship to Patient