



Consent for Treatment & Financial Agreement

Patient's Name: _____ Date: _____

I consent to treatment necessary or desirable to the care of the patient mentioned above, including, but not restricted to, preventative and restorative treatments that may be performed by the attending dentist, hygienist, or dental assistant.

I understand that the patient or responsible party is **solely responsible** for payment of all services, although the insurance carrier may be billed for said services. If this account becomes overdue, I agree to pay all reasonable costs of collection including any legal fees.

I authorize the release of any information needed to process my child's insurance claims. I further understand that I am responsible for the entire cost of treatment regardless of insurance coverage or payments. I authorize pay of insurance benefits directly to Cumberland Pediatric Dentistry and Orthodontics.

I understand that some services are not always covered by my insurance company based on the necessity. I understand that if any treatment is rejected or downgraded by my insurance plan, **I will be billed for those services**. I acknowledge as a member of this/these insurance plan(s) that this office will submit my insurance claim and **I will be responsible for paying all co-pays and/or deductibles at the time of the visit**.

I authorize my insurance company to remit payment of services directly to this office for services provided.

I understand that it is my responsibility to give the doctor at least 48 hours' notice if I am unable to keep my child's scheduled appointment. In the event that I do not give a minimum of 48 hours' notice and do not come to my child's appointment, Cumberland reserves the right to charge a cancellation fee. This will compensate for the time reserved to treat my child and disallowed another patient to receive treatment due to my lack of notice.

I hereby authorize and acknowledge that any scanned/electronic signatures are to be considered an original signature.

I hereby acknowledge that I understand and agree to the above conditions.

Responsible Party Signature: _____ Date: _____