Goodhue FAMILY DENTAL

## CONSENT

**I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.**
**Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.**
**I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.**
**Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account. I further understand that I am responsible to pay reasonable attorney's fees and costs of collection in the event of default.**
**I agree to give at least a 48 hour notice in advance of rescheduling an appointment. When an appointment is broken with less then 48 hours notice, I understand that the office has the right to charge my account the customary fee.**

## AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

**I authorize the health care provider to submit claims for payment for services to the health care service plans or insurance companies named, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.**

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**I authorize the dentist or other health care provider to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits.**
**If my coverage is under a group master agreement held by my employer, and association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.**

**This authorization shall remain effective for up to five years from this Date.**

**I know that I have the right to receive a copy of this authorization if requested.**

_____ _____
(PATIENT) Date

_____ _____
(PARENT OR RESPONSIBLE PARTY) (RELATIONSHIP TO PATIENT)