Esthetic Design Dental

Consent to Treat

This is to certify that I, _____ consent to the performing of the dental and oral surgical procedures agreed to be necessary of advisable, including the use of local anesthetics (if applicable), and I will assume the responsibility for fees associated with the procedures.

The information included in the health history is accurate to the best of my knowledge.

_____ _____

Signature Date

_____ _____

Signature of Parent/Guardian in case of Minor Date

Financial Responsibility

I, _____, authorize Esthetic Design Dental, to file insurance claim on my behalf. I as the patient or (responsible party) take full responsibility for my entire account balance.

Payment is due at the time of treatment. We accept cash, Visa, Mastercard, Discover, check, and Care Credit.

I understand that, prior authorization submitted to my insurance company is not a guarantee of payment but an estimate of benefits payable.

I understand that my dental insurance is a policy between me and the insurance company and that if there is a problem with a benefit that I am responsible to contact my insurance company.

Card on File Notice:

A credit or debit card is required to be placed on file prior to being seen. For ALL balances, if a billing statement is sent and payment is not received within 30 days, the stored credit or debit card will AUTOMATICALLY be charged for any balance due on the account.

_____ _____

Signature of Patient (or Responsible Party) Date