Dr. Kathleen McDonald

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost uncured in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charges directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms and assists in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Thus, if the insurance company denies the dental claim for any reason, the patients, or guardian will be responsible for the full dental fee. I hereby authorize the office of Kathleen McDonald, D.M.D. to release any information regarding my claim for dental benefits. I understand all co-payments and deductibles are due at time of service. I understand that the fee estimate listed for this dental care only is extended for a period of six months from the date of the patient's examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable services value of said services to said Doctor, or her assignee, at the time services are rendered, or within five (5) days of the billing if credit shall be extended. I further agree that the value of said services shall be billed unless objected to me, by me, in writing, within the time for payments thereof. I further agree that a waiver of any breach of any type or condition hereunder shall not constitute a waiver of any further term or condition and I fully agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

A service charge of 1 ½ %per month (18%) per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial agreements are satisfied. Should the account be referred to a collection agent, the undersigned also agrees to pay additional 40% collection fees, costs, and interest charged by the collection agent.

Our office accepts cash, personal checks, American Express, Discover Card, Master Card and Visa as payment. For those who need extended payment plans, our office participates with CareCredit. For all minor children brought to this office for treatment, we consider both parents finally responsible for all costs incurred in treating your child regardless which parent brings the child to this office. In the case of divorce, both parents will be held responsible until the account is paid. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. When the office schedules an appointment for you, we are reserving our doctor's and or hygienist's time for you. With this in mind**, I agree to give 24 hours notice when canceling or rescheduling appointments; if I fail to do this, I understand there will be a $25.00 charge.**

I have read and understand the above Consent for Service and agree to its content for myself and my family.

_____ DATE:_____ Relationship to Patient:_____

Signature of Patient, Parent or Guardian