RESPONSIBILTY AND CONSENT STATEMENT
FAMILY DENTISTRY

Cuong B. Tran, DMD FAGD
3570 Hamilton Blvd, Suite 302
Allentown, PA 18103
(610) 841-7555

Date_____

I hereby authorize and request the performance of dental services for myself or for:

_____Age_____

_____Age_____

_____Age_____

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes of dental treatment.

For your convenience, we offer the following methods of payment. Payment is due in full at each appointment. Please check the option you prefer:
___Cash _____Personal check _____ Mastercard _____Visa ____Care Credit Financing

INSURED PATIENTS

As a courtesy to you, insurance forms will be filed by our office. We must **EMPHASIZE** that as care providers, our relationship is with the patient, not with the insurance company. If we do not receive payment from your insurance carrier within 90 days, payment becomes the responsibility of the patient.

MISSED APPOINTMENTS AND OVERDUE ACCOUNTS

Unless cancelled, at least 24 hours in advance, our policy is to charge $25 for missed appointments. Please help us serve you better by keeping your scheduled appointments. It this becomes a problem we have the right to terminate you as a patient. Also if an account remains unpaid for more than thirty days, without other arrangements made, we have the right to review your account and dismiss you as a patient.

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage, and is payable at the time of service. In the event an invoice becomes 30 days or more past due and no other prior arrangements have been made, it will be placed with Hamilton Law Group for collection. I/we agree to pay a service charge of 1.5% per month (18% APR), and any and all collection and reasonable attorney fees.

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Signature of Responsible Party