RESPONSIBILITY AND CONSENT STATEMENT

TRAN DENTAL

Cuong B. Tran, DMD, MAGD, FICOI
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 ___ Credit Card

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 ACCOUNT

Our office policy requires cancellations be made two business days prior to an appointment to avoid a missed appoint fee of $45.00. Please help us serve you better by keeping your scheduled appointments. If this becomes a problem we have the right to terminate you as a patient. Also if an account remains unpaid for more that 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 the balance 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 attorney fees.

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Signature of Responsible Party