George S. Skoog D.D.S. Family Dental Practice

Consent for Care and Treatment

I, the undersigned, do hereby agree to give my Practice to furnish dental treatment to and proper in diagnosing or treating his/her co	consent for the George S. Skoog D. D. S. Denta considered necessary
Patient/Guardian	Date
Benefit Assignment and Release of I	nformation
Dental Practice. A photocopy of this assignment	al benefits to which I am entitled, including surance payors to the George S. Skoog D. D. S. ent is to be considered as valid as the original. Information necessary, including Dental Records,
Patient/Guardian	Date
Financial Policy Statement	
	y to you. You are responsible for the entire bill. Your estimated share be made at time service is mit payment within 60 days, the balance will be
If any payment is made directly to you for servi promptly remit same to the George S. Skoog D	
	y of the payments for which I am responsible in a s of collecting monies owed, including court costs
If three consecutive appointments are cancelle be charged.	d without at least 48 hours notice a \$50 fee will
The above information has been read and explithe payment of my account.	ained to me. I understand my responsibility for
Patient/Guardian/Responsible Party	Date