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

Consent for Care and Treatment

I, the undersigned, do hereby agree to give my consent for the George S. Skoog D. D. S. Dental Practice to furnish dental treatment to _____ considered necessary and proper in diagnosing or treating his/her condition.

Patient/Guardian_____ Date_____

Benefit Assignment and Release of Information

I, the undersigned, do hereby assign all medical benefits to which I am entitled, including Medicare, private insurance, and third party insurance payors to the George S. Skoog D. D. S. Dental Practice. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Dental Records, to secure payment.

Patient/Guardian_____ Date_____

Financial Policy Statement

We will bill your insurance carrier as a courtesy to you. You are responsible for the entire bill. We require that arrangements for payment of your estimated share be made at time service is rendered. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you.

If any payment is made directly to you for services billed to us, you recognize obligation to promptly remit same to the George S. Skoog D. D. S. Dental Practice.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

If three consecutive appointments are cancelled without at least 48 hours notice a $50 fee will be charged.

The above information has been read and explained to me. I understand my responsibility for the payment of my account.

Patient/Guardian/Responsible Party_____ Date_____