

*Milford Dental Clinic*  
*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 patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

I understand the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient exam.

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

Patients who carry dental insurance understand that all dental services furnished are charged 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 or assist 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.

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

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.

**I have read the above conditions of treatment and payment and agree to their content.**

\_\_\_\_\_ Date: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Signature of patient, or responsible party

**Referral Information**

Whom may we thank for referring you to our practice? \_\_\_\_\_