Dr. Mark Tall at Sandcreek Dental

Financial Information

* I authorize Sandcreek Dental to release any information required to process my claims and necessary in the course of examination and treatment. I further assign my insurance proceeds and/or dental benefits to Sandcreek Dental and authorize my insurance company and/or benefits administrator to pay these assigned proceeds/benefits direct to Sandcreek Dental. Any estimate by us regarding insurance benefits is only a guideline. We cannot make any guarantee of the insurance payment as estimated.

*** I understand that I am financially responsible for all the charges whether or not paid by my insurance and/or benefits administrator** and that Sandcreek Dental will submit billings to my insurance company only as a courtesy to me. **I am responsible to know my dental benefits**, insured that my insurance company and/or benefits administrator pays these benefits to Sandcreek Dental, and **to negotiate with my insurance company and/or benefits administrator over any disputed claim.**

*** I, the undersigned client/guardian, agree to pay for all services rendered and/or goods sold to me or my ward immediately upon demand by Sandcreek Dental.** I further agree that in the event of non-payment to Sandcreek Dental of any amounts due under this agreements I will pay interest thereon at the rate of 1.5% per month(18% annually) and pay all of Sandcreek Dental's reasonable legal fees and court costs that may be incurred. I agree that in the event of this agreement being assigned to a collection agency for collection I promise to pay a collection fee of 35% if the unpaid balance due which is in addition to the unpaid balance due under this agreement.

* There will be an additional fee of $25.00 for returned checks.

*** Delinquent accounts will be promptly referred to a collection agency.**

We accept cash, personal checks, all major credit cards, and Care Credit.

I have read and understand the above stated financial policies of this office.

Patient/Guardian Signature Date

Consent for Treatment

I hereby authorize the doctor or designated staff to take x-rays, intra-oral pictures, photographs, study models and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon, diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon to provide proper care. I agree to the use of anesthetics, sedatives, and any other medications if necessary. I understand I can ask any questions for possible risks or complications.

Patient/Guardian Signature Date