BRENDEN & BRENDEN

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Dr. Amanda Brenden Dr. Reed Brenden

OFFICE CONSENT FOR TREATMENT & FINANCIAL ARRANGEMENT

A. **Consent for Treatment:** I give consent to my dentist, other attending dentists and their assistants and designees, to provide me with such dental, surgical, diagnostic, or other treatment services judged necessary and/or appropriate. This consent includes my consent for diagnostic procedures and all dental treatment rendered at my dental office under his/her instruction; including x-ray, laboratory procedures, and all dental treatment or medication, monitoring, and all other procedures or treatment that do not require my specific informed consent. I authorize the release of information regarding my dental care and protected health information to carry out treatment, payment activities and healthcare operations.

B. **General Acknowledgements:** I understand that no guarantees have been made to me with respect to the results of my examinations or treatments. I understand and agree that I may be observed and/or receive care from dental and other health care students in training at my dental office. I understand that it is my responsibility to follow instructions about and make arrangement for follow-up care as directed by my dentist. I understand that I may review and obtain a copy of my dental record, at my own expense, and that this review shall take place during regular business hours.

C. **Assignment and Agreement to Pay:** I understand that I am responsible for payment of the services I receive and guarantee payment for these services. I understand that payment is due at the time of service. I authorize release of information to carry out treatment, payment activities and healthcare operations; including submissions of 3rd party insurance claims and patient billing. Not all insurance companies pay the usual and customary fees of dentists and I understand that I am responsible for any applicable co-payment, deductibles, co-insurance and/or non-covered costs and charges. I understand and agree that I am responsible for the cost of collection and/or attorney fees related to my account. I understand that my health information will be released to my insurers, payers, or others for billing purposes.

D. **Insurance Acknowledgement:** I acknowledge that it is my responsibility to understand the benefits of my insurance plan and its requirements when seeking treatment and/or care not provided by my primary care provider. **I authorize payment of the dental benefits otherwise payable to me directly to the dentist providing service.**

E. **Privacy Notice:** I acknowledge that I was provided with a copy of the notice of Privacy Practices. Please refer to the Notice of Privacy Practices for more information regarding release of your health information and your right to access your health information.

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Signature of Patient/Authorized Representative Date

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Relationship of Authorized Representative

If unable to sign document, state reason:_____