GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. **Should there be any change in my health status in the future, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another healthcare provider may be necessary, and I consent to the release of this information. I authorize release, to my insurance company/plan administrator, the information contained in claims electronically and for direct assignment to the dental office, if applicable. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

Financial Responsibility Agreement
By signing below, I acknowledge and agree to the following:

- I understand that, regardless of my insurance status, I am fully responsible for all balances and for all services provided.
- I understand that my insurance policy is a contract between me and my insurance company, and any remaining balance not covered by insurance is my responsibility.
- I understand that full payment, including co-payments and deductibles, is due at the time of service.

Please Note: A potential fee of $50 may be charged for any missed/rescheduled appointments without 2 full business day's notification.

X_____
(Signature) Patient ___ Parent___ Guardian___ (print name of guardian)

Date:_____ Reviewed by Treating Dentist: _____