

CONSENT FOR SERVICES

ALL PATIENTS:

• METHOD OF PAYMENT - PLEASE CHECK ONE:

- Check or Cash at time of Treatment
- Visa or Mastercard
- Insurance, with Co-payment, at time of Treatment

- **Payment In full is expected at time of treatment.**
- **Patients with verified insurance may pay only their co-pay, including deductible, at the time services are rendered. Please be sure to read and sign the insurance section.**

I HAVE COMPLETED THE HEALTH QUESTIONNAIRE TO THE BEST OF MY KNOWLEDGE. I DECLARE ALL ANSWERS AND INFORMATION PROVIDED ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH, I WILL INFORM THE DOCTORS AT THE NEXT APPOINTMENT WITHOUT FAIL.

I GIVE MY CONSENT FOR NEEDED DENTAL SERVICES AND USE OF PROPER AND ACCEPTABLE METHODS TO COMPLETE SAME . I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT RENDERED FOR _____ .

(PATIENT'S NAME)

SIGNED _____ DATE _____

(GUARDIAN OR RESPONSIBLE PARTY)

INSURANCE INFORMATION / ASSIGNMENT OF BENEFITS

PATIENTS WITH INSURANCE:

- **As a courtesy to our patients, we will be happy to file your Insurance.**
- **Co-payment, including deductible is expected at time of treatment.**

I I HAVE READ, AND UNDERSTAND, THE INSURANCE POLICY PROVIDED BY THIS OFFICE. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS, OTHERWISE PAYABLE TO ME, TO THE DENTAL PRACTICE OF:

ROBERT S. BROOKS, D.D.S. AND B. WELLS MADDOX III, D.M.D.

SIGNED _____ DATE _____

(INSURED PARTY)