Agreement and Consent to Render Dental Care

Appointments

Each appointment represents a specific amount of time reserved for your child's dental care. If a problem arises and you are unable to keep this time, we request proper notification or cancellation. A charge will be made for failed appointments.

We will make every effort to schedule appointments for your child at your convenience. In order to provide quality care for your child's comfort and well being, the appointment may conflict with school or other activities.

Insurance

We will file your insurance and will do our very best to maximize your benefits. We accept assignment of benefits (payment released to Dr. Rita Tamulis-Shea) to lower your immediate "out of pocket" expenditures. We simply ask that you take care of your estimated portion of payment at the time of service. As a children's specialist, occasionally our fees may be above what the insurance company considers "usual and customary."

Consent

State law requires us to obtain consent for your child's dental treatment. I hereby authorize to have my child treated for the necessary dental work. We will inform you of all other services and their fees prior to treatment.

I also understand that I am personally responsible for the fees of services rendered. In the event that Dr. Rita Tamulis-Shea seeks enforcement of this agreement, by the way of recognition, they shall be responsible for and incidental expenses including all collection costs.

I hereby state that I have thoroughly read and understand this consent form. I have been given an opportunity to ask questions about the procedures(s) which have been answered in a satisfactory manner. I understand further that I have the right to be provided with answers to questions which may arise during the course of my child's treatment.

I understand I am able to withdraw my consent to treatment at any time, and this consent will remain in effect until such time that I choose to terminate it.

Patient's Name _____

Signature of Parent/Guardian _____

Date_____ Time_____ am/pm

Relationship to Patient _____

I certify that I explained the above procedures to the parent or legal guardian before requesting their signature.

Signature of Dentist/Office Coordinator _____ Date _____