BeGentle Dentistry

4027 S. LaFountain St. Kokomo IN 46902

1107 E. Broadway St. Logansport IN 46947

Consent for Care

I hereby authorize to have x-rays, study models, photographs or other diagnostic aids taken, as deemed appropriate by Doctor to make a thorough diagnosis of my (dependent's) dental needs. I also authorize Doctor to perform any and all forms of treatment, medications and therapy that may be indicated. I further authorize and consent that Doctor choose and employ such assistance as deemed fit. I understand the use of anesthetic agents embodies a certain risk. If a sedative drug is prescribed, I (my dependent) understand such medication can affect judgement; consequently, I (my dependent) release this office from liability if I (my dependent) do not abide to strict instructions to **not** drive a motor vehicle when under the influence of sedative drugs.

Financial Consent

I understand that financial responsibility for dental services provided by this office for myself (or my dependents) is mine, due and payable at the time of services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge (18% annually) may be added to any balance over 60 days. In the event of default, I am to pay legal interest on the indebtedness, together with collection cost and reasonable attorney fees as may be required to effect collection of the amount owed.

For patients with dental insurance:

I hereby assign eligible benefit payments directly to this office. To the extent permitted under applicable law, I authorize the release of any information for the purpose of obtaining payment for services rendered. I understand that my insurance is a contract between my employer and insurance carrier. I further understand that UCR (usual, customary, reasonable) fees differ from all insurance plans; consequently, my copayment may be an estimate. I am still responsible for all dental fees including the amount not paid by my insurance.

Cancellations & Broken Appointments

In an effort to keep dental costs down while maintaining a high level of professional care, we respectfully request a 48 hour cancellation notice. Your scheduled time has been saved only for you and the doctor or hygienist.

I have read the above consent. I understand and agree to comply with the consent as applicable to me or my dependents.

Signature of patient or Responsible party: _____

Printed name: _____ Date: _____

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