Adamson Family Dentistry

Financial Information

Our office accepts cash, personal checks and MasterCard/Visa/Discover or Care Credit for payment of dental services rendered.

All patients are expected to make payment at time of service.

If you have dental insurance, we will be glad to bill your insurance company for you, however you are responsible for paying services rendered at the time of service. Insurance patients authorize the release of any dental information necessary to process their claim with their insurance company.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. All accounts with a balance over 30 days will be assessed a 1.5 percent late charge per month on the unpaid balance. If your account becomes delinquent and is assigned to a collection agency, you agree to pay 25% collection agency fees, court costs and attorney fees.

Should you need to cancel an appointment, please give 48 hour notice otherwise a cancelled appointment fee may be charged. This fee will be charged at our discretion and may vary depending on the length of the broken appointment.

Consent For Treatment

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

Upon such diagnosis, I Authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

Patient's Signature_____ Date_____ Witness_____

Parent/Responsible Party's signature_____ Relationship to Patient_____