

**Consent for Services**

Please review, initial and sign below:

\_\_\_\_\_ As a condition of my treatment by Marci S. Morris, DDS, PC financial arrangements must be made in advance. All emergency dental services or any dental service performed without previous financial arrangements must be paid for at the time services are performed.

\_\_\_\_\_ I understand that all dental services are charged to me and that I am responsible for the payment of all dental services. I understand that as a courtesy, Marci S. Morris, DDS, PC will help to prepare my insurance forms or assist in making collections from insurance companies and will credit such collections to my account. However, the office cannot render services on the assumption that the charges will be paid by the insurance company.

\_\_\_\_\_ I understand that a returned or declined check is subject to a non-refundable processing fee of \$50.00.

\_\_\_\_\_ I agree to a service charge of 1.5% per month (18% per annum) on any unpaid balance exceeding 60 days, unless previously written financial agreements have been made.

\_\_\_\_\_ If my account is referred to a collection agency or to an attorney for collection, I agree to pay all collection fees and court costs, including collection agency fees or attorney’s fees in the amount of thirty-three and one-third percent (33 1/3%) of the total indebtedness then due.

\_\_\_\_\_ In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to the said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

\_\_\_\_\_ I understand that I must notify the office 48 hours prior to my appointment time for any cancellations. Failure to do so will result in a broken appointment fee of \$50.00 for every 30 minutes of time scheduled. I also understand that being substantially late for any appointment or missing an appointment is subject to a broken appointment fee.

\_\_\_\_\_ The philosophy at Marci S. Morris, DDS, PC, is to provide patients with the highest quality of dental care. Therefore, amalgam, or silver fillings are not performed at this practice. I understand that my insurance company may downgrade or not fully cover tooth colored, or white fillings and that I will be fully responsible for the difference in cost.

“I have read the above conditions of treatment and payment and agree to their content in its entirety.”

Name of Patient (please print) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient \_\_\_\_\_