Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. If for any reason your insurance company has not paid within 60 days, you will be responsible

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

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 Dr. Gary A. Hartman, 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/We ________________________ (guarantor) agree to be financially responsible for the cost of all dental services rendered to the patient by Dr. Gary A. Hartman. If payment for these services is not made when requested, I agree to pay, in addition to my account balance, all cost of collecting my account balance, which cost may include interest, collection/attorney's fee, and all court cost expended in the collection of this dental account. 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.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: ____________ Relationship to Patient: ____________________

Signature of patient, parent or guardian

______________________________ Date: ____________ Relationship to Patient: ____________________

Signature of guarantor of payment/responsible party

HIV/ Hepatitis B Consent

HIV and Hepatitis B are blood borne pathogens found in bodily fluids, such as, blood and saliva. These blood borne pathogens can be passed from one person to another by these bodily fluids. Because we are working inside the mouth there is a risk of exposure by a sharp instrument or needle for anesthesia. Universal precautions are used throughout this dental practice and it is extremely rare for this kind of exposure to occur, however, in the event that either the doctor or staff member is exposed to one of these pathogens a blood test will need to be done on both the patient and the exposed staff member. This test will be done at the expense of this dental practice. Both the patient and the exposed staff member will be informed of the test results. A copy of both tests will be kept in this office and a follow up test will need to be taken 6 months from the date of the first. These precautions are to protect you as a patient, as well as our staff members. Please sign and date on the lines below acknowledging that you have been informed of the risks and understand the above statement. Your signature also gives consent for a blood test if there is an exposure incident during your dental procedure.

______________________________ Date____________ Relationship to patient: ____________________

Signature of patient, parent or guardian