Consent for Treatment

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance/Medicaid coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

________________________________ Relationship__________________ Date__________________

Signature of patient
or authorized responsible party