

**Mary J. Powell, DMD, P.C.**

**FINANCIAL POLICY & CONSENT FOR TREATMENT**

**Basic Policy:** Payment for services rendered is due in full at the time of service. Our office accepts cash, personal checks (with valid drivers license), and credit cards (Visa, MasterCard, Discover, and Care Credit). There is a \$30.00 returned check fee due and payable from you for each check payment returned to us by your bank.

**For Patients with Insurance:** As a service to our patients, we will verify insurance benefits and collect what your policy will not pay on the day of service. **Every effort will be made to closely ESTIMATE** your co-payment and deductibles which are due at the time of service, **but the ultimate responsibility for any unpaid balance rests on you. PLEASE UNDERSTAND THAT INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY.** If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full by you. I have read and fully understand the above consent for financial responsibility and insurance authorization.

**Cancellation of Appointments:** Please give 24 hours notice if you are unable to keep your appointment. A \$25.00 missed appointment fee may be assessed for failing to give 24 hours notice. The practice reserves the right to dismiss patients with excessive cancelled or failed appointments.

**Signature on file:** I request payment of authorized insurance benefits to be made on my behalf to Mary J. Powell, DMD, P.C., for services provided me by listed facility and/or physician.

**General Consent for Treatment:** The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

**Certification of Patient or Legal Guardian:** I have completed this form and I certify that I am the patient or legal guardian of the patient. I authorize the release of all medical records to physicians that I am referred to by this office and my insurance company. I will allow the fax transmittal of records, if necessary.

**Consent to contact by phone:** I, the undersigned, give Mary J. Powell, DMD, PC, its employees, and/or agents "express prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance, or payment.

**Agreement to pay:** I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all cost of collection, (33.33%), attorney fees and /or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

\_\_\_\_\_  
PRINT PATIENT NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT/LEGAL GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
RESPONSIBLE PARTY SIGNATURE

\_\_\_\_\_  
DATE