Churchman & Roberts Dentistry, LLC
Dr. Mary Seale Churchman Dr. Katie Courville Roberts
GENERAL DENTISTRY

Consent for Dental Treatment

1. I authorize Dr. Churchman and/or Dr. Roberts and her staff to perform all services necessary for proper dental care to myself and my dependent(s) whether or not I am present at the actual appointment when the treatment is rendered.
2. I understand that dentistry is not an exact science and, therefore, reputable practitioners cannot fully guarantee results.
3. I understand that no guarantee or assurance has been made by anyone regarding the dental treatment that I have authorized.
4. This consent form will remain valid until revoked by me in writing.
5. I understand that local anesthesia is necessary for most treatment. I understand that although it is extremely safe, some rare complications may occur, such as ecchymosis, paresthesia or permanent anesthesia.

Acknowledgement of Financial Responsibility for Services Rendered

1. I understand that I am financially responsible for services rendered on behalf of myself or my dependent(s), whether or not covered by the insurance.
2. I understand that payment is due in full when services are rendered, unless prior arrangements have been made.
3. I understand when accounts are 30 days past due, I am responsible for all costs of collections including, but not limited to, attorney's fees, court cost, late fees, statements fees, and postage.
4. I understand that as treatment progresses, fees may have to be adjusted due to unforeseen circumstances.
5. I understand that this office does not provide free dental services.
6. **If you must change your appointment, we request a 24 hour notice** so that the time reserved for you can be given to another patient. **A $50.00 broken appointment fee may be charged to patients with confirmed appointments who fail to keep their appointments or who do not give 24 hour notice of cancellation.**

Assignment of Insurance Benefits (If Applicable)

1. I authorize and request my insurance company to pay directly to Dr. Churchman and/or Dr. Roberts all insurance benefits, if any, otherwise payable to me or my dependents for services rendered.
2. I authorize Dr. Churchman and/or Dr. Roberts to release all information necessary to secure payments of benefits.
3. I authorize the use of this signature on all insurance submissions.
4. **I understand that my dental insurance carrier may pay less than the actual bill for services and I am responsible for the remaining balance.**

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Signature Date

Churchman & Roberts Dentistry, LLC