SUSAN L. SOCKWELL D.M.D.

CONSENT FOR SERVICES

(For Patients without Dental Insurance)

I give consent for exams and treatment by Susan Sockwell DMD and staff. I understand that I have the opportunity to ask for clarification of procedures as they become necessary. I may refuse any treatment understanding it may result in loss of teeth and further complications.

_____ Date: _____ Relationship to Patient _____

Signature of patient, parent or guardian, or guarantor of payment/responsible party

FINANCIAL POLICY

1. You are ultimately responsible for your bill.
2. Payment is always due at the time services are rendered. If you have any questions regarding the amount due at each appointment, please ask.
3. We do not offer payment plans but do offer CareCredit. You can go to www.carecredit.com to see if you are eligible.
4. Any fee quoted will be honored for 6 months from the date the treatment is planned.
5. If collection procedures become necessary, the patient is responsible for all collection and legal fees.
6. Failure to show up for a scheduled appointment with at least a 24 hour notice is subject to a $50 broken appointment fee.
7. Returned checks are subject to a $25 return check fee.

I have read the above Financial Policy and understand that I am responsible for paying for all services rendered by Susan Sockwell DMD and staff on the date of service.

_____ Date: _____ Relationship to Patient _____

Signature of patient, parent or guardian, or guarantor of payment/responsible party