Patient Name _____ Account Number _____

Release of Information

I authorize **Dr. Michael Edwards** to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of my dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to **Dr. Michael Edwards** any and all dental insurance benefits otherwise payable to me.

I understand that I (and my dental insurance company) am responsible for payment for my dental treatment. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or on behalf of my dependents.

signature of patient _____ signature of responsible party other than patient _____ date _____

Financial Arrangements

For your convenience, we offer the following methods of payment. We will take assignment of dental insurance benefits and defer that portion of the payment with the proper authorization and the necessary insurance forms and/or information. If assignment of benefits is accepted, payment for any balance due after the benefit is paid will be billed for and be due and payable immediately. If payment is not received within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. Please check the method of payment which you perfer.

_____ Cash

_____ Personal Check

_____ Credit Card _____ VISA _____ MC ___ DenCharge

_____ Other (Other arrangements made only with approval prior to treatment)

I realize that failure to keep this account current may result in denial of additional dental services other than emergency treatment. In the case of default on payment of this account. I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future account balances.

signature of patient _____ signature of responsible party other than patient _____ date _____