(205) 988 - 4470
NickBrownDental.com

2041 Valleydale Road
Birmingham, AL 35244

PATIENT CONSENT

1. I understand the the information I have provided is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

2. The undersigned hereby authorizes Dr. Nick Brown and his staff 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.

3. I also authorize Dr. Brown to perform all recommended treatment mutually agreed upon by me and to use the appropriate mediation and therapy indicated for such treatment (Name of Patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that Dr. Brown choose and employ such assistance as deemed fit to provide recommended treatment.

4. For each appointment, we reserve a patient room, your records and insurance is pre-checked, and special instruments are prepared. Due to the preparation time involved, please give at least 48-hours notice to change or cancel your appointments.

5. Patients who have dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this office cannot render services on the assumption that our charge will be paid by an insurance company.

6. As a courtesy to you, we process secondary dental claims and make every effort to ensure an accurate estimate of your out-of-pocket cost. Please note that some secondary dental insurance may deny payment if primary pays any portion of a claim.

7. Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due, and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge per month may be added to my account thereafter. Should full payment not be made when due the undersigned agrees to pay all costs, collection fees and a reasonable attorney fee not to exceed 33%. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition.

Patient _____ Date _____
Parent or Responsible Party _____
Realtionship to Patient _____