Kirby-Cochran Center for Dental Health, LLC
416 Martling Rd. • Albertville, AL 35951

ADDITIONAL INFORMATION AND CONSENT FOR SERVICES

Responsible Party Information

Name of person financially responsible: _____
Relationship to patient: _____
Social Security Number: _____ Birth Date: _____
Address: _____
Method of payment: ☐Cash ☐Check ☐Credit Card
Bank: _____ Account Number: _____
Credit Card: _____ Account Number: _____

Employment Information

Employer's Name: _____ Occupation: _____
Employer's Address: _____ Phone: _____
Spouse's Employer: _____ Occupation: _____
Employer's Address: _____ Phone: _____

Primary Insurance Information

Name of Insured: _____ (Last / First / MI) Is insured a patient: ☐Yes ☐No
Insured's Birth Date: _____ ID Number: _____ Group Number: _____
Insured's Address: _____ (Street / City / State / Zip Code)
Insured's Employer's Name: _____
Insured's Social Security Number: _____
Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other
Insurance Plan Name and Address: _____

Secondary Insurance Information

Name of Insured: _____ (Last / First / MI) Is insured a patient: ☐Yes ☐No
Insured's Birth Date: _____ ID Number: _____ Group Number: _____
Insured's Address: _____ (Street / City / State / Zip Code)
Insured's Employer's Name: _____
Insured's Social Security Number: _____
Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other
Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry 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 insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this denial care can only be extended tor a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. IN THE EVENT OF NON-PAYMENT OR DEFAULT, I AM RESPONSIBLE FOR All COSTS OF COLLECTION, INCLUDING BUT NOT LIMITED TO COLLECTION AGENCY FEES, COURT COSTS, AND REASONABLE ATTORNEY FEES.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature guarantor of payment/responsible party: _____ **Date:** _____ **Relationship to Patient:** _____