Medway Family Dental
General Treatment Consent
&
Office Policies

1.) Direct Authorization for general treatment (Preventative, Restorative, Prophylaxis and X-rays by Unique Smile Dental Associates. I authorize Unique Smile Dental Associates for myself /parent/guardian on behalf of the Minor
Patient._____ Initial

2.) FINANCIAL AGREEMENT
Payment is due at the time of service. As a courtesy to you, we will submit all charges to your insurance company. Insurance is designed to cover a portion of our fees only; Your Co-pay will be collected at each appointment. I authorize my Insurance Company to make direct payment to Unique Smile Dental Associates._____ Initial

3.) CANCELLATION AND FAILURE TO KEEP APPOINTMENT
We understand that circumstances do arise that can keep you from your scheduled appointment. We require a 72 hour notice to change/cancel any appointment, as a result of this policy the following charges may apply. General/Hygiene $60.00. Specialist 5 days notice$110.00_____ Initial

4.) X-Rays
Original x-rays are the property of Unique Smile Dental Associates. If you request to have your x-rays duplicated, there will be a $28.00 charge. Please allow 72 hours for duplication processing, prior to pick up or mailing. _____Initial

5.) APPOINTMENT REMINDER CARDS/COURTESY CONFIRMATION CALLS/TEXTING/ EMAIL
I GIVE Unique Smile Dental Associates permission to send a reminder post card by U.S. post office,via internet, telecommunication. _____Initial

6.) COLLECTIONS
Failure to pay your balance within 90 days; your account will be sent to a collection agency. There will be a $50.00 charge to process the collections account. _____Initial

By signing below, I understand and agree to the above listed General Consent for Treatment and Office Policies, for treatment and services rendered.

Patient/Parent/Guardian_____Date_____