

Conditions for Dental (Healthcare) Treatment

Authorization for Medical Treatment: I authorize and consent to dental (healthcare) services including, but not limited to, diagnostic, cosmetic and dental procedures and treatment at Carol F. Morgan, DDS, P.C. I understand that no guarantees or promises have been made to me as to the result to be obtained from such services.

Financial Agreement: In consideration for dental (healthcare) services provided to me and/or a person whom I claim financial responsibility (family member) by Carol F. Morgan, DDS, P.C. for this and all subsequent services, I agree to pay Carol F. Morgan, DDS, P.C. in accordance with their regular rates and terms of payment. I assume full responsibility for payment of all charges associated with the dental (healthcare) services provided to me and/or any person whom I claim financial responsibility (family member), including any portion any charges not paid by insurance carriers, workers' compensation or any other party or entity. Such unpaid charges may include, but are not limited to, deductible and coinsurance amounts. I agree to pay a cancellation fee if I do not notify Carol F. Morgan, DDS, P.C. of cancellation 48 hours (2 business days) prior to my appointment. Should my account become delinquent, I agree to pay all collection costs and expenses, including attorney's fees, interest and court costs, additionally, I waive homestead and all other exemptions to such debt.

Assignment of Benefits: In consideration for dental (healthcare) services provided to me by Carol F. Morgan, DDS, P.C. for this and any subsequent services, I hereby assign to Carol F. Morgan, DDS, P.C. any and all rights, benefits and claims I may have under any policy of insurance (dental, hospitalization, major medical, automobile, liability, workers' compensation, and any other) and the proceeds from any claim against third parties or med pay carriers that I may have for injuries. Such assignment hereby authorizes direct payment to Carol F. Morgan, DDS, P.C. under and/or from any such policy of insurance or proceeds.

Co-Guarantor: I _____, understand that by signing this document, I agree to accept financial responsibility for dental care (healthcare) provided by Carol F. Morgan, DDS, P.C. to the patient identified below. If the patient is either physically or legally unable to sign at registration, I accept this "Conditions for Services" on behalf of the patient.

I certify that I have reviewed this document in full, understand its terms, and have had the opportunity to ask questions regarding its content. I understand that this document is valid and remains in effect unless revoked by Carol F. Morgan, DDS, P.C.

Patient: _____
Print Name

Signature

Date: _____

Co-Guarantor _____
Signature

Date: _____