

Ramsin K. Davoud, D.D.S.
Family and Aesthetic Dentistry

Guest Name: _____

Welcome to our practice. We appreciate your selection of our office to serve your dental health needs. Our goal is to provide the very best care for our guests,
Please read the following statements. The guest or guest's legal guardian must sign.

General Release

The undersigned hereby authorizes the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed to make thorough diagnosis of the guest's dental needs. I further authorize and consent that the doctor may consult with my physician or other health care providers regarding my dental health and treatment. I also authorize the doctor to perform any form of treatment, medication, and/or therapy that may be indicated. I understand that the use of anesthetic agents and certain treatments embody some risk. In good faith, the doctor will present these risks and alternatives to proposed treatment and my questions will have been answered in order to proceed.

FINANCIAL RESPONSIBILITY

Part of our commitment to quality dental care is to provide you with information about your dental hygiene needs and treatment, including the **ESTIMATED** cost of your dental care. Our fees are individually based on the time, severity, and difficulty of your specialty treatment. Payment is expected at the time of service. We accept cash, check, Visa, MasterCard, American Express and Care Credit. A \$25.00 fee will be charged on all returned checks and a 1.5% service charge will be assessed on all accounts not settled within 30 days of service. If in an unforeseen event an account is turned over for collections; be advised the responsible party is liable for all late fees and/or collection charges appropriately applied to the account.

THERE WILL BE A \$50.00 PER HOUR FEE FOR BROKEN APPOINTMENTS OR APPOINTMENTS NOT CANCELLED WITHIN 48 HOURS OF THE SCHEDULED APPOINTMENT. _____ **Initial**

I understand that I am responsible for any payment due for services that I have received. I am also responsible for any outstanding balance after my insurance carrier has paid the claim for service. _____ **Initial**

I understand payment is expected at the time of service. _____ **Initial**

I understand that it is important to be on time for my appointments. Being on time allows the dental team to provide the high standard of care I am entitled to receive. _____ **Initial**

To reserve my seating for appointments PRE PAYMENT is required. _____ **Initial**

Name: _____ Relationship to Guest: _____

Signature: _____ Date: _____

Credit Card Pre-Authorization Please keep this signature on file to cover any unpaid balance.

Circle One: AM EX CARE CREDIT DISCOVER HSA MASTERCARD VISA
Card # _____ Exp. Date _____

Cardholder Signature: X _____