Patient's Name: _____ **Patient's Date of Birth:** _____

I understand the following financial responsibility:

Patients without dental insurance: All fees are due at the time services are rendered, unless other arrangements have been made in advance. I assume full responsibility for payment of services rendered, finance charges, collection and/or attorney fees required in the collection of this account. I understand there is a $30.00 service charge for any returned (NSF) checks.

Patients with dental insurance: Any "patient portion"/insurance deductible/copayments are due at the time services are rendered, unless other arrangements have been made in advance. I assume full responsibility for payment of services rendered, finance charges, collection and/or attorney fees required in the collection of this account. I authorize payment of my dental insurance benefits to New Orleans Dental Center. I am responsible for monitoring the use of my insurance benefits and whether my maximum covered benefit will be exceeded**. Much hard work is done to find out the most accurate information regarding my insurance benefits as possible; however, it is only an estimation.** If my account has any outstanding balance at 60 days after the date of service (whether my insurance company has paid benefits or not), I am responsible for that balance. I understand there is a $30.00 service charge for any returned (NSF) check.

Scheduling Agreement

We consider your time to be valuable; therefore, your appointment is reserved just for you. As a courtesy, we will text and/or email you reminders before your appointment. If you do not reply, we will try to reach you by phone. We require a 48-hour notice to change or cancel an appointment. (For Monday appointments, we require notice by the previous Thursday). The fee for a missed appointment is $75.00.

Designation of Personal Representative

I authorize the following individual(s) to obtain information or make decisions in regard to my dental treatment and/or dental records:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

_____ (initials) I authorize detailed voice mail messages to be left on my home/cell phone.

Notice of Privacy Practice Acknowledgement

I acknowledge that I have read the New Orleans Dental Center's Notice of Privacy Practices, which contains a complete description of the use and disclosures of my health information.

My signature below certifies that I understand and agree to all of the above.

Signature: _____Date: _____

Print Name: _____ Relationship to patient: _____