ACESSIBLE DENTAL SERVICES – PRIVATE PAY AGREEMENT

Patient Name: _____ Date:_____/_____/_____

ACKNOWLEDGEMENT

I have authorized Accessible Dental Services (ADS) to provide comprehensive oral treatment and/or rehabilitation for myself or for the above-named patient. I understand that the treatment and/or rehabilitation (i.e. comprehensive examination, full mouth x-ray series, cleaning and fluoride treatment, periodontal scaling and root planning, minor periodontal surgery, soft tissue excisions and biopsy of lesions, amalgam and composite restorations, crowns, bridges, root canal treatment and extractions) may not be covered entirely by my, or the patient's, insurance.

I hereby certify that I am the patient, the legal guardian of the above referenced patient, or have otherwise been empowered to give consent on behalf of this patient for dental treatment and extractions. As such, I agree that ADS may bill my, or the patient's, Medicare, Medicaid/Department of Public Welfare or other third party insurance for the dental treatment provided. Billing shall be the responsibility of ADS; I will cooperate to the degree necessary to provide documentation regarding insurance coverage, as from time to time it may be necessary to secure payment from the appropriate entity.

I am the patient and/or I agree to act as guarantor for any unpaid services and/or invoices that qualify for private pay. ADS will send a consolidated statement, of 30 days, to me as the patient or designee. Payment will be due 30 days from the consolidated statement date. In the event payment is not received, ADS reserves the right to recoup private pay charges for unpaid services via utilization of a collection agency. In the event that I, or the patient, does not qualify for dental coverage through an insurance plan, I will act as guarantor. I understand that ADS offers payment plans for dental services and that failure to pay in full and/or engage in a qualifying payment plan will disqualify myself and/or the patient from scheduling for future dental appointments with ADS.

I have read, understand, and agree to, the above. My questions have been answered and intending to be legally bound hereby I consent to the Private Pay Agreement for Comprehensive Dental Treatment.

_____ _____/_____/_____

Signature of Parent/Guarantor Date

_____ _____

Printed Name Relationship to Patient (Self/Guarantor)