PATIENT NAME ___________________________________

I acknowledge that I have received the following:

Initials

(_________) Dental Materials Fact Sheet

(_________) Notice of Privacy Practices

I authorize the performance of any laboratory, x-ray or other studies that may be used by Jeffrey H. Lind DMD or his designated staff as deemed appropriate to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize Jeffrey H. Lind DMD and his designated staff, to perform all recommended treatment mutually agreed upon by me.

I understand and agree that I am fully responsible for payments of all services rendered on my behalf or my dependents, regardless of any insurance coverage that I might provide. I further understand that any balances on my account after 60 days will be assessed a finance charge of 18% APR.

I understand that the contract I have with my dental insurance company is between the insurance company and myself, and does not involve Dr. Lind, but if I provide Dr. Lind's office staff with complete information relating to my dental insurance, they will assist me by submitting my claims and interceding on my behalf. I authorize Jeffrey H. Lind DMD and his staff to release information to my insurance company or companies including diagnoses, records or any treatment or examinations rendered. I consent to have payments paid directly to Jeffrey H. Lind DMD from my insurance company.

$50 missed appointment fee

Remember a broken appointment hurts three people…you, another patient and me. As a result our office requires 24-hours notice, or you will be charged $50 per hour of appointment time. This means that you must call 24-hours ahead of your appointment time if you wish to cancel, NOT the night before or the morning of your appointment. Please do not wait for us to call and confirm your appointment and then cancel at that time.

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Signature (Patient or responsible party) Date

Print Form