

## **CONSENT AND FINAL AGREEMENT**

### **CONSENT TO DENTAL TREATMENT**

The undersigned consents to the dental procedures which may be performed during treatment at Thomas P. Cosgrove DMD, PC, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, oral surgical treatment or procedures, or local anesthesia rendered to the patient by the dentist.

### **RELEASE OF INFORMATION**

I agree that to the extent necessary to determine liability for payment and to obtain reimbursement, the dentist may disclose portions of my dental records to any person or corporation which is or may be liable for all or any portions of the dentist's charges, including but not limited to insurance companies, dental or health care service plans, or workers' compensation carriers. I understand that dental information may also be released to review organizations and if necessary any agencies that may be involved in continuing patient care. I agree and acknowledge that this authorization and consent continue until such time as written notice revoking said consent from the patient or the patient's legal representative is received by the dentist. Such revocation as above stated will not apply retroactively to any previous disclosures made based on the original authorization.

### **FINANCIAL AGREEMENT**

**ASSIGNMENT OF INSURANCE BENEFITS:** In the event the patient is entitled to dental care arising out of any insurance policy insuring patient of any party liable to the patient, said benefits are hereby assigned to Thomas P. Cosgrove DMD, PC for application on patient's bill, and it is agreed that this office may receipt for any such payment and such payment will discharge the said insurance company of any and all obligations under the policy to the extent of such payment, the undersigned and/or patient being responsible for charges not covered by this assignment.

**FINANCIAL AGREEMENT:** The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account in accordance with regular fees and terms of this dental office. Furthermore, he will be obligated to make monthly payments if requested, and upon discharge, on the uninsured portion of the account. Should the account be referred to a collection agency or any attorney for collection, the undersigned will pay all reasonable attorneys' fees and collection expenses. Any accounts 90 days delinquent are subject to 21% annual interest charge on any un-paid balance. This office reserves the right to make appropriate entries on the undersigned's personal credit report in regards to any delinquency in their account with this office thru Holloway Credit Solutions, LLC.

**I, (we) hereby guarantee THOMAS P. COSGROVE DMD, PC, payment of all charges in accordance with its rules, regulations, and charges. Furthermore, I (we) hereby authorize and appoint the administrator of this office or his successor/designee as my attorney-in-fact to take measures in my behalf as may be necessary to collect any such claims or insurance proceeds by signing my name as attorney-in-fact to any such claims and/or forms.**

THE UNDERSIGNED CERTIFIES that he has read the foregoing, and is the patient as patient's general agent to execute the above and accept its terms.

**GUARANTEE OF PAYMENT,** in consideration of dental services extended to this patient, I/we do hereby assume responsibility for the payment of all charges for such services in accordance with the financial agreement above.

**BROKEN APPOINTMENTS: Cancelled/Missed appointments without 24 hours notice are subject to a twenty five dollar fee.**

**ALL DEDUCTIBLES AND CO-PAYS ARE DUE AT TIME SERVICES ARE RENDERED**

**IF YOUR CLAIM IS DENIED IN PART OR IN FULL THE PATIENT WILL BE FINANCIALLY RESPONSIBLE**

Signature of responsible party \_\_\_\_\_ Date \_\_\_\_\_