Consent of Treatment

The undersigned hereby authorizes Drs Raymond J. Gove and Sarah M. Gove and or designated staff members to take necessary radiographs, study models, photographs, or any other diagnostic aids required to make a thorough diagnosis of existing conditions. I further authorize Drs Raymond J. Gove, Sarah M. Gove, or designated staff members to perform any and all forms of treatment, including administering of medications and delivery of therapy that may be indicated. I understand that the use of any anesthetic agents involve certain risks that will be discussed prior to treatment.

Missed, Failed and Cancelled Appointments

There is a $50 charge for all missed, failed, and cancelled appointments without a 24- hour notice.

Returned Check:

Returned checks will be subject to a $50 returned check fee and will result in possible cash only transactions with future visits.

Financial Agreement

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express, and Care Credit

I hereby agree to be responsible for charges for all services rendered by Gove Family Dentistry. I hereby assign directly to Gove Family Dentistry payment of my dental insurance benefits applicable to these services and authorize the collection of such funds on my behalf. Such payments shall not exceed my balance owed to Gove Family Dentistry. I acknowledge and understand that I am the guarantor whether signing or my behalf, or if signing as a patient's agent, legal guardian, or closest relative. I am personally responsible for all charges not paid by my insurance. It is my responsibility to be aware of the insurance benefit available for each dental treatment. Delayed or denied insurance payments could result from missing or incorrect information. I also certify that any information which I have provided is true and correct.

In the event of non-payment, I will be held liable for collection costs including but not limited to: collection agency fees, reasonable attorney fees which you expressly agree shall be the greater of: (1) fifty percent (50%) of the unpaid balance or (2) $400 court costs and interest at a rate of 18% per year, calculated daily, beginning from the last date of service or the last payment date. Unpaid balances shall also be subject to a data transfer of derogatory information about any unpaid balance to one or all of the three major credit bureau reporting agencies (Experian, Equifax or Trans Union) By signing below, you expressly authorize any collection agency or attorney involved to not only transmit this information, but also to request a copy of your personal credit report from one or more of the above referenced credit reporting agencies.

I certify that I have read and understand the above financial agreement as well as the medical and dental history form. To the best of my knowledge, the written questions have been accurately answered.

Signature of Patient/Guardian/Parent of Minor

X_____ **Date:** _____

Printed:_____