MASON, FAITH & HOSCHEIT DDS, LTD
2035 Foxfield Road, Suite 103
St. Charles, IL 60174

Welcome to Our Practice. Thank you for choosing Mason, Faith & Hoscheit DDS for your dental needs. We are so happy that you are here. We will do everything we can to make your visit with us a very pleasant experience. Let us know how we can further assist you.

CONSENT

After explanation by the doctor, I hereby authorize the performance of dental services upon the above-named patients and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

TERMS AND CONDITIONS

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Insurance Authorizations

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefits plan, unless prohibited by law, or the treating dentist of dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

COLLECTION AUTHORIZATIONS

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days, from the date of the patient's examination. I also understand upon non-payment for service and in the event of multiple billing, I will be assessed a rebilling fee of $35.00. I, the undersigned, hereby agree that in the event of default in the payment of any amount due, and if this account is placed with a collection agency, for collection or any subsequent legal action, to pay an additional collection fee of 30% of the account balance due, as well as any attorney fees and court costs incurred and permitted by laws governing these transactions.

THERE MAY BE A CHARGE FOR ANY MISSED APPOINTMENTS OR APPOINTMENTS NOT CANCELLED 48 HOURS BEFORE THE APPOINTMENT TIME

Printed name of Patient or Personal Representative:

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Signature of Patient or Personal Representative:

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