General Consent for Dental Care
Office Financial Policy
Dental Associates of Leominster/Groton

GENERAL CONSENT FOR DENTAL PROCEDURES

I,_____ allow Dr. Yuric J. S. Chang D.M.D. and staff to treat me, prescribe medication, take diagnostic Xrays, make models and impressions, give local anesthetics, perform routine restorative procedures (fillings; amalgams and resins), removable devices (dentures and partials), extraction of teeth, placement of dental implants and all procedures within the scope of dentistry as deemed necessary.

Signature _____ **Date**_____

REGARDING INSURANCE ASSIGNMENT

A signature on file is required for most insurance forms, to be assigned to this office. I, _____ allow my signature to be used for the practice, Dental Associates of Leominster, to obtain insurance assignment.

Signature_____

REGARDING PAST DUE ACCOUNTS AND COLLECTIONS

It is always the patient's responsibility for their own accounts regardless of insurance. Thus, in the unfortunate instance that Dental Associates of Leominster is forced to send repeated bills with no prior written approval for financial arrangements by Dr. Yuric Chang, there will be a **10% finance charge applied to all outstanding bills** that will accrue over time. To avoid this, responsible parties are encouraged to pay their statements in a timely manner. All persons responsible will be pursued and held accountable for all fees and court costs will be entirely the responsibility of the debtor.

REGARDING COPIES OF PATIENT RECORDS/FILES

The law allows patient access to their files. However, the originals are property of Dental associates of Leominster and copies will be made available to patients and released with a written consent by the individual. There is a copy fee of **$25.00 single file and $50.00 family** due prior to release of copies. these copies may or not may not contain Xrays over five years due to film life, but will contain all necessary information Dental Associates of Leominster has on file.

Thank you for understanding our policies. Pleas ask any questions if you have any concerns. I, _____ understand and agree to this office's policies.

Signature_____ **Date**_____

Signature of Patient or Responsible Party

Signature_____ **Date**_____

Signature of Co-Responsible Party