8000 W. G. Penny Lane
Louisville, Kentucky 40219

Family Dental Associates

Telephone (502)969-2396

CONDITIONS OF ADMISSIONS AND TREATMENT

CONSENT TO TREAT: I grant permission to Family Dental Associates and its' staff to render dental care and treatment to me / my dependent _____
I have provided true and correct information on the patient information forms as an application for services and treatment. I agree to cooperate and participate in my or my dependent's care.

FINANCIAL CONSIDERATIONS: In all cases,treatment needs, their cost, and payment options will be explained in detail and agreed upon before any treatment begins.

As a courtesy to all of our patients with insurance, Family Dental Associates will file your claim for benefits and mail it for you. We are also happy to accept assignment of benefits so that you will only be responsible for paying the estimated co-payment at the time of service. However, you must understand that the estimate of benefits is just that--- an estimate. By signing below you understand that you are ultimately responsible for payment in full for services rendered regardless of whether or not your insurance company pays any or all of your claim for benefits and that you assign to and authorize payment to Family Dental Associates all benefits payable under the terms of any insurance policy presented for coverage of treatment received at Family Dental Associates.

If your account becomes delinquent and is transferred to an outside agency for collection, you will be liable for any fees or court costs incurred by Family Dental Associates to collect on your account.

Note to Divorced Parents: It is not possible for Family Dental Associates to become involved in divorce settlements regarding financial responsibility for dental care. The parent bringing the child in for services is responsible for payment for those services.

RELEASE OF INFORMATION: By signing below, I understand that Family Dental Associates may disclose all or any part of my or my dependent's treatment record to any third party which is or may be liable for payment of services rendered by Family Dental Associates. Otherwise, this information will be held in strict confidence and only released with your written permission, except as may be required by law.

ACKNOWLEDGEMENT: I have read, understand, and accept the conditions of admissions and treatment.

_____ Date:_____
Patient &/or Responsible Party

_____
Witness