ALBERTO J AMBARD, DDS, MS

INFORMED CONSENT FORM FOR GENERAL DENTAL CARE

I hereby authorize Dr. Alberto J. Ambard to administer dental treatment such as examinations, x-rays and anesthetics as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition. I understand that the use of local anesthetics embodies a certain risk, including prolonged numbness and in very rare occasions; nerve damage. I also understand that during dental treatment, there is a risk of an inhaled or swallowed instrument. In case of this extremely rare accident, Dr. Ambard would take all necessary actions which could include sending me to emergency room.

During your first visit, a complete examination will be performed. The cost of the examination will vary according to the necessary records needed for the diagnosis of your dental condition, and the records available from previous dental offices. **Because we are fee for service, we respectfully ask you to pay your first visit consultation and x-rays in full at time of service.**

Going forward: Patient portions are due at time of service and as treatments are rendered per financial agreements and estimates. As a courtesy to you, if you have insurance ***and we are in network*** we can submit a pre-authorization if requested and we will bill for applicable reimbursement from your insurance. If we do not receive payment from your insurance within 30 days from the date of service, the claim becomes your responsibility and the balance must be paid in full by you. Benefits quoted by our staff members or by your insurance company are never a guarantee of coverage or benefits and are considered estimates; it is your responsibility to know your benefits by your individual insurance plan.

Pre-Authorizations: We will be happy to help you obtain medical or dental preauthorization from your insurance company, for treatments that have not been scheduled if you request it, once an insurance responds, preauthorization's are valid for period of 30-90 days.

Ultimately, please keep in mind that this is a ***fee for service practice,*** and that ***you*** are responsible for all costs of treatment, including charges for services not paid by your benefit plan. Financial arrangements will be discussed after you have decided to proceed with the recommend treatment. Accounts with a balance more than 90 days old will accrue interest at 18.5% APR. Accounts forwarded for collections will assume the responsibility of any court costs, filing fees, and attorney's fees.

Thank you

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Patient/Responsible Party Signature Date