Richardson DMD, Inc.

Billing and Consent Authorization

Patient Name (or legal guardian): _____ Date of Birth: _____

By signing below, I acknowledge that I have been informed of the treatment plan and associated fees and I consent to treatment. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan unless prohibited by law, or the treating dentist or 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 to Dr. William Richardson or Richardson DMD, Inc.

I acknowledge that I am responsible for communicating with the front desk staff any questions I have regarding my treatment plan.

If this is my first visit, I recognize a treatment plan will be created and I am responsible to understand what my treatment plan will entail. Additionally, I am responsible to directly work with my insurance company to understand what I may owe beyond what my insurance company covers.
I further acknowledge that if my treatment plan is more than six months old, service rendered may reflect changes to the fees associated with my treatment plan.

Please note, a patient who has broken two appointments within a 6-month period may be dismissed from the practice or put on probation in the practice. A copy of our policy is available upon request.

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Patient Name: _____ Date of Birth: _____

Patient or Legal Guardian Signature: _____ Today's Date: _____