Millington Family Dentistry
Bolland Dental, PLLC

We appreciate the opportunity to serve you and desire to provide you with the best service possible. The information below is intended to ensure you are aware of certain treatment, financial and privacy policies. If you have any questions, please inform a member of our front desk staff.

CONSENT FOR TREATMENT

I desire to be seen and treated by Taylor Bolland, DMD (and/or his associates) and hereby give my consent for the clinic, its physicians and employees to see and treat me, as they deem necessary and appropriate for diagnosis and treatment. I authorize and consent for examinations, blood tests, and laboratory procedures, injection of medications, local anesthesia, surgery, and other services, treatments or procedures rendered or performed at the clinic or ordered by its physicians or employees. I further understand that state law requires our practice report any communicable diseases to the health department.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices) has been made available to me.

CONSENT FOR FINANCIAL RESPONSIBILITY

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service (e.g., deductions, copayments, and non-covered services.) **I understand a parent must accompany child to every appointment.**

I request authorized benefits be made on my behalf to Taylor Bolland, DMD for any services furnished to me. I authorize any holder of medical information to release to the insurance carrier any information needed to determine these benefits payable for related services.

It is my responsibility to contact my insurance company and/or employer to verify that Dr. Bolland is a participant in my insurance plan. If my insurance plan requires a referral, it is my responsibility to obtain the referral prior to being treated. If a referral is required and I fail to obtain one, I will be financially responsible for any services rendered.

I understand that I am financially responsible for all charges not payable by insurance, including annual deductible, copayment, coinsurance, and any non-covered/cosmetic services. If I am without verified health insurance or with a plan which Dr. Bolland does not participate, I am required to pay in full at the time services are rendered. In the event my insurance company denies any claim or pays my claim as "out-of-network", I am responsible for the balance.

If it becomes necessary, I also understand that I am responsible for reasonable collection costs and/or attorney fees incurred for collection of this account. I agree, that in order to service my account or to collect any amounts owed to practice, I may be contacted by telephone at any telephone number associated with this account, including wireless telephone numbers, which could result in charges to me. I may also be contacted by text messages or emails, using any email address provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Our practice accepts cash, check, bank debit card, Mastercard, Visa, American Express or Discover. Each instance of a returned check is subject to a $50 processing fee. There will be $30 fee for duplication or transmission of dental records.

Signature of Patient OR Parent/Legal Guardian, if minor _____ **Date:**_____