"CONSENT FOR TREATMENT"

-I authorize Dr. Fragola and any of his agents or employees to treat me.
-The procedure necessary has been explained and I have an understanding of the nature of the work.
-I have been informed of possible alternative methods of treatment including no treatment at all.
-It has been explained to me and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.
-I have been given the opportunity to question the doctor concerning the nature of the treatment, the inherent risks and the alternatives to this treatment.
-This consent form does not encompass the entire discussion I had with the doctor regarding the proposed treatment.

"INSURANCE"

To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient. Please be aware that each individual insurance company bases there payment of fees upon their own individual fee schedule; which are not always concurrent to the fee directly charged by us to the patient. Additionally, this office is not responsible for the collections of benefits from your insurance company.

I agree to the fee for treatment and have the responsibility to pay the balance before treatment is completed. I also understand that if payment is not made by me, that I will additionally be responsible for any costs (collection and legal) that are incurred by the doctor in obtaining my final payment. Balances not paid within 30 days of completion, will be subject to a finance charge, currently at 18% per year, 1.5% per month.

By signing this document, I acknowledge that I have read it entirely, fully understand it's contents and have answered all questions on both sides truthfully.

Date _____ Signature _____

SUBSEQUENT TREATMENT:

Date _____ Signature _____

Date _____ Signature _____

Date _____ Signature _____

Date _____ Signature _____

****PLEASE NOTE****

After your last visit for root canal therapy, you must return to your general dentist for final restoration of the treated tooth or teeth.