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Consent for Services

I understand that the information that I have given today is correct to the best of my knowledge. I authorize the dental staff to perform any necessary dental services with informed consent that I may need during diagnosis and treatment. I understand I will be charged 1.5% service charge on all balances over 90 days retroactive to the date of service and the account will be assessed monthly.

I realize that failure to keep this account current may result in Decatur Family Dentistry being able to provide additional services except for dental emergencies or where there is prepayment for additional services.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay the reasonable value of said services, to said doctor, or her assignee at the time of services rendered, or within five (5) days of billing, if credit shall be extended. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition. I further agree to pay all cost and reasonable attorney fees if suit be instituted hereunder.

Financial Options

1. 10% prepay discount off patient charges of \$1000 or more (verified check or cash only)
2. Credit Card
 - VISA
 - Discover
 - Diners Card
 - American Express
3. CareCredit (for \$300 or more upon approval)
4. Two (2) installments payable on day of preparation and day of cementation for crown and bridge.
5. Four (4) installments payable on the day of each appointment for partials and dentures.

I grant my permission for this dental practice (or its assignee) to telephone me at home, work or otherwise, to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature _____ Date _____ Relationship to Patient _____