CARL J. DISPENZIERE, D.D.S.

General, Cosmetic and Implant Dentistry

I knowingly and voluntarily request and consent to the services, treatments and/or procedures recommended by Carl J. Dispenziere, D.D.S. which may include, but are not limited to dental x-rays, imagery, study models and any other aids deemed necessary for diagnosis and treatment. I authorize Dr. Dispenziere to perform all services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that Dr. Dispenziere may engage the assistance of others in performing such services, treatments and/or procedures utilizing such diagnostic methods. I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been implied or made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended.

I understand and acknowledge that I am fully and completely responsible for the payment of all fees associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by Dr. Dispenziere and others. I acknowledge that any insurance coverage benefit that I may have is based upon a contract between my insurance company and me, or my spouse's insurance company and my spouse. Dr. Dispenziere is not a party to any such contract, and all services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to Dr. Dispenziere for all services, treatments, procedures and/or methods provided to me. As a courtesy to me, the dental office will bill my insurance company, and I acknowledge that I will remain liable for any and all fees that are not paid by the insurance company for any reason. This includes, but is not limited to the insurance company declining coverage after initially approving coverage, any "waiting period" implemented by the insurance company, and/or, if the insurance company fails to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide Dr. Dispenziere with my current dental insurance information and any changes thereto.

I understand that all returned checks are subject to a $25 returned check fee. Any account balances that remain unpaid after 90 days from the date of service shall accrue interest at a rate of 18% per year, and may be referred to a collection agency or attorney. Further, in the event that any unpaid account balance is referred to an attorney for collection, I agree to be responsible for any and all costs and reasonable attorney fees incurred in connection therewith.

I consent to Dr. Dispenziere's use and disclosure of my health information as well as my personal information to my insurance company and any agent thereof. I hereby assign to Dr. Dispenziere, all insurance benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me, and I authorize my insurance company to make payment directly to Dr. Dispenziere for all fees associated therewith. In the event that the insurance company pays me directly, I agree to reimburse Dr. Dispenziere for any outstanding or unpaid balance on my account, including any finance charges.

I further consent to be contacted by Dr. Dispenziere, any agent of the dental office, any collection agency (or agent thereof) or any attorney (or agent thereof) to whom an unpaid account balance has been assigned or referred, by mail, fax, mail, or telephone number I have provided to the dental office or any agent thereof.

By signing this form, I attest to the fact that I have read its contents and fully agree to all terms outlined.

_____	_____	_____
Signature of Patient (or Parent/Legal Guardian)	Printed Name of Patient (or Parent/Legal Guardian)	Date