



**Consent for Treatment**

I, the undersigned or authorized individual acting on behalf of the patient, agree to give my consent for **Kathy J. Farley, D.D.S., P.A.** to administer dental care and treatment to \_\_\_\_\_ as considered necessary and proper in the diagnosis and treatment of the patient.

Patient/Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

**Benefit Assignment/Release of Information**

I hereby authorize this office to apply for benefits on my behalf for covered services rendered. I hereby assign all dental benefits to which I am entitled directly to Kathy J. Farley, D.D.S., P.A. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure payment.

Patient/Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

**Release of Information**

I authorize Kathy J. Farley, D.D.S., P.A. and her associates to release and/or send medical/dental information regarding my case to other consulting and/or referring physicians/dentists.

Patient/Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

**Financial Policy Statement**

I understand that my insurance is a contract between the insurance carrier and me, and not between the insurance carrier and this office. I understand that I am still fully responsible for all fees. Should timely payments of this account not be made, I authorize **Kathy J. Farley, D.D.S., P.A.** to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. Any expense incurred by such action shall become an additional liability for which I assume responsibility.

Patient/Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_