Consent

I hereby authorize East Hills Dental Center to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of my dental needs. I also authorize the dentist to perform any and all forms of treatment, medication and therapy, that may be indicated. I understand the use of anesthetic agents embodies a certain risk.

I give East Hills Dental Center permission to file dental insurance on my behalf and consent for the insurance to send payment to the dental office. I assign all insurance payments to East Hills Dental Center. I understand that the dental insurance is my benefit and that responsibility for payment for dental services is mine.

Payment is due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge of 1.5% per month (18% annual rate) will be added to any overdue balance after 60 days. If for any reason my account goes into collections I will be responsible for all collection fees.

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ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Text Document.