104-60 Queens Boulevard
Parker Towers, Suite B
Forest Hills, NY 11375
(718) 459-7900

Office & Financial Policy Form

SECTION A: CONSENT FOR PATIENT			
FIRST NAME		LAST NAME	
BIRTH DATE		TELEPHONE	
EMAIL			

SECTION B: TO THE PATIENT (OR ADULT GUARDIAN)
Please read the following statements carefully

PURPOSE OF CONSENT
By signing this form, you acknowledge that you have read and understand our practice's financial policies as stated below.

OFFICE / FINANCIAL POLICIES

- I authorize my physician (pediatrician) and any hospital (if my child has been hospitalized) to release any and all pertinent medical information.
- Since the patient is a minor, it becomes necessary that a signed permission is obtained from a parent or legal guardian before any dental services can be started and accomplished by Dr. Cheirif.
- It is the policy of this office to bill for any missed appointments unless given at least 48 hours notice. I understand that unless I give such notice, I will be charged $50.00. (Note: Three late arrivals will be considered a missed appointment.)
- I authorize payment of dental benefits directly to the dentist. I further authorize the release of any information necessary to process these dental claims. I understand that I am financially responsible for all deductibles, co-payments and non-covered services that may apply as directed by my insurance plan. I am aware that eligibility is not a guarantee of coverage as actual benefit payments are determined only when a claim is adjudicated.
- Should my insurance be terminated during the course of my treatment, I understand that I am financially responsible for any services rendered.
- I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit references.
- I further understand this consent will remain in effect until such time that I choose to terminate it. I understand that I accept responsibility for payment of services rendered.

SIGNATURE OF:	❑ PATIENT	❑ PARENT		
	❑ LEGAL GUARDIAN	❑ AGENT UNDER DURABLE POWER OF ATTORNEY		
PRINTED NAME	*First Name*	*Last Name*		
SIGNATURE			DATE	