GENERAL CONSENT & FINANCIAL RESPONSIBILITY

I understand that dentistry is not an exact science and that the office of Dr. Les Kurian and/ or his associates (collectively referred to as "Dentist") cannot guarantee results from the treatment done to which I have requested and authorized to do. I understand that each Dentist is and individual practitioner and is individually responsible for the dental care and treatment rendered to me. I hereby authorize the Dentist to proceed with and perform and dental examination and treatment(s) and that I understand any risks and complications that may occur during treatment. I understand and acknowledge any treatment alternatives and options explained to me by the Dentist. I understand that this is an estimate of fees and are subject to change or modifications due to unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that the Dentist may need to refer me to a dental specialist(s) to start and/ or complete and procedure that has been treatment planned and that I will be responsible for any additional fees charged to me by the dental specialist(s).

I understand that regardless of any dental insurance coverage I may have, that I am responsible for the payment of all dental fees for treatment that has been rendered by the Dentist. I understand that all fees quoted for any treatment planned are only an estimate of fees of such said treatment plan until insurance payment is received by the Dentist. I agree to pay any attorney fees, collection fees and court fees that may incur to satisfy this obligation. I hereby authorize payment directly to the above named Dentist that is otherwise payable to me for dental services rendered and all payments not received by the due date shall be submitted to a collections agency. I authorize release of any necessary information relating to my dental claim.

Should any dispute arise over dental services provided to me, said dispute will be submitted to arbitration and the decision by arbitration shall be binding on both parties. I agree that a photocopy of this authorization shall be as valid and effective as the original forever.

This is my consent to the examination and dental treatment performed by Dr. Les Kurian and/ or his associates. I am of legal age and legally competent to make this agreement.

Our dental office appreciates a 24- hour notice if you are unable to keep your scheduled appointment. If you fail to give notice at least 24 hours in advance, there will be a charge of $50.00. We require a $100.00 nonrefundable deposit for major restorative treatment.

Patient Name (Print Name):_____ Date:_____

Signature: _____

Dentist (signature):_____

Submit