Manning Dental Associates

Dr. Bryan A. Manning
Dr. Vincent K. Williams

Consent for Dental Treatment

- I authorize Dr. Bryan Manning and/or Dr. Vincent Williams and their staff to perform all services necessary for proper dental care to myself and my dependent(s) whether or not I am present at the actual appointment when the treatment is rendered.
- I understand that no guarantee or assurance has been made by anyone regarding the dental treatment that I have authorized.
- I understand that local anesthesia is necessary for most treatment. I understand that although it is extremely safe, some rare complications may occur, such as ecchymosis, paresthesia or permanent anesthesia.
- This consent form will remain valid until revoked by me in writing.

Acknowledgement of Financial Responsibility for Services Rendered

- I understand that I am financially responsible for services rendered on behalf of myself or my dependent(s), whether or not covered by insurance.
- I understand that payment is due in full when services are rendered, unless prior arrangements have been made.
- I understand when accounts are 60 days past due, I am responsible for all cost of collections including, but not limited to, attorney's fees, court cost and late fees.
- I understand as treatment progresses, fees may have to be adjusted due to change in treatment.
- **We request a 24 hour notice if you must change your appointment. A cancellation fee may be charged to patients with confirmed appointments who do not give a 24 hour notice or who fail their appointments.**

Assignment of Insurance Benefits (If Applicable)

As a courtesy, we will assign a staff person to assist you in attempting to verify your dental insurance coverage, determine the limitations of your policy, identify your maximum dental insurance benefits, and assist you with filing the necessary forms, so that you receive the benefits to which you are entitled.

There is no guarantee of insurance coverage or payment. You should be aware that your dental insurance company does not guarantee payment, does not cover all procedures, and may not pay for any dental services provided. There is no guarantee we are in your dental network.

By signing below, you acknowledge that you have been fully informed in advance of receiving treatment that your insurance may deny payment for some or all of the dental services that may be recommended and provided by your dental care provider in this office.; you agree to be responsible for payment in full for charges, including "Covered Services" denied by your insurance.

- I authorize and request my insurance company to pay directly to Manning Dental Associates all insurance benefits.
- I authorize Manning Dental Associates to release all information necessary to secure payments of benefits.
- I authorize the use of this signature on all insurance claims.
- **I understand that my dental insurance carrier may pay less than the actual bill for services and I am responsible for the remaining balance.**

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Signature Date