Dr Barbra Shea Perkins, D.M.D

Newburgh Family Dental

8788 Ruffian Lane Suite B

Newburgh, IN 47630

INFORMED CONSENT FOR DENTAL EXAMINATION AND/OR TREATMENT OF A MINOR

I am the parent or guardian of _____ who is a minor. I hereby authorize and consent to any x-ray, examination, anesthetic, sedative or dental treatment rendered under the direct supervision of Dr. Barbra Shea Perkins, D.M.D., and her staff members, or agents, as she may deem necessary.

This authorization will remain in effect until cancelled in writing.

Parent Signature_____

Date_____

DENTAL FLUORIDE FOR MINORS

It is our policy to treat all minors under the age of 13 with 60 second fluoride treatments two times per year. Unfortunately, many Insurance companies will only pay for this treatment once per year. We feel this treatment is necessary for developing teeth and will prevent future cavities. The additional fluoride treatment may cost you up to $24.00 based upon your Insurance.

Signing below states you **ACCEPT** this treatment for your child. You may choose to change you decision at any time.

Parent Signature_____

Date_____

Barbra Shea Perkins, D.M.D. P.L.L.C dba Newburgh Family Dental

Patient name(s)_____

_____

Patient address_____

MISSED APPOINTMENT FEE

I understand that I will be charged a fee of $30 for any missed doctor's appointment that I fail to cancel at least 24 hours in advance. This fee will be waived if appointment is missed due to bad weather or emergency situations. However, we would appreciate a courtesy call when applicable.

AGREEMENT TO PAY/AUTHORIZATION FOR INSURANCE PAYMENT

I agree to pay for all fees or my portion not covered by my dental insurance for the above mentioned patient, at the time of service. I realize I am also responsible for full payment of fees, not paid for by insurance within 30 days of notification by Barbra Shea Perkins D.M.D. P.L.L.C. I also agree to be responsible for any fees required to collect payment for services including: attorney and court costs, collection agency fees, pre-judgment and/or post judgment interest at the current legal rate.

I hereby authorize my insurance company to pay directly to Barbra Shea Perkins D.M.D.

COLLECTION FEE

I understand that I have 90 days from the first bill to pay my balance in full. After 90 days my account will be assessed a fee of up to 50% of the account balance and sent to a third party/collection agency: I agree to pay that fee and all other fees associated with attorney and/or court costs. I understand and agree to the above terms.

I received a copy of the Notice of Privacy Practices for Newburgh Family Dental.

Signature_____ Printed name_____ Date_____