Campbell Family and Cosmetic Dentistry
48 Piedmont Drive Suite 302
Winder, GA 30680
770-868-8788

Consent for Services

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.
I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents, regardless of insurance coverage. I understand and agree that I am responsible for any portion of my bill that my insurance company does not pay within sixty days of claim submission. I understand payment is due at the time of service. In the event payments are not received by agreed upon dates, I understand that a $5.00 rebilling fee will be added to my account if the account is not paid in full by the due date of the first billing cycle.

_____ _____ _____
Signature of patient, parent, or guardian Date Relationship to patient

Acknowledgement of Receipt of Privacy Practices and HIPAA Statement

I have received a copy of the Notice of Privacy Practices and a copy of the HIPAA statement for the above named practice.

_____ _____ _____
Signature of patient, parent, or guardian Date Relationship to patient

Insurance Authorization

I authorize release of information to all my insurance carriers

I understand that I am responsible for any part of my bill not covered by my insurance

I understand that I will be billed for treatment not paid by my insurance sixty days after claim submission

I authorize payment directly to my doctor

I authorize my doctor to act as my agent in helping me obtain payment from my insurance

_____ _____ _____
Signature of patient, parent, or guardian Date Relationship to patient

*** We reserve on our schedule the necessary time for you to receive your recommended treatment. We ask that you please give us at least 24 hrs notice of any cancellation of an appointment. Thank you.**