



## COUNTY DENTAL ACKNOWLEDGEMENT AND CONSENT OF RECEIPT OF OFFICE PROCEDURES

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### PLEASE REVIEW

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All co-payments and deductibles are due at the time of visit, unless prior arrangements have been made with the Office Manager and have been signed and dated on a treatment agreement form.

A \$ 25 fee will be assessed for all appointments cancelled without a 24 hour notice prior to the scheduled appointment.

Patient is responsible to understand the parameters of their insurance, and is responsible, at the time of visit, for any expenses incurred which are not covered by their plan.

Because your insurance reserves the right not to pay a claim due to their statutes of limitations, any non-paid claims will be the responsibility of the patient to pay said claim at the reimbursement rate of your insurance.

By signing below I give consent to County Dental to administer dental treatment for myself or to my child, whether or not I am present at such visits.

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I \_\_\_\_\_, have received a copy of  
PATIENT / GUARDIAN

the office policies and consent to the terms stated above.

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**(PLEASE PRINT E-MAIL)**

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(SIGNATURE)

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(DATE)