

Rappold Family Dentistry  
20 Losson Road  
Suite #110  
Cheektowaga, NY 14227  
716-668-9700

## **CONSENT FOR PROCEDURES & PAYMENT OF FEES**

This is to certify that I, undersigned, give consent to the performance of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthesia. I acknowledge and understand that I am personally responsible for all fees for service rendered including all costs incurred by Rappold Family Dentistry for collection of any unpaid balances including, but not limited to, attorney fees in the amount of 1/3 of the outstanding balance owed to Rappold Family Dentistry interest, court costs, disbursements and any other related costs

Unless otherwise arranged, payment for professional service is required on the day treatment is rendered. Rappold Family Dentistry accepts insurance as a courtesy and will submit claims on your behalf, however, we are not responsible for errors in processing of such claims leading to delay or nonpayment by the insurance company based on information furnished to us by the patient, and therefore the patient will be personally responsible for making all payments.

Please give a least 24 hours' notice if you cannot keep your appointment, otherwise you will be charged a broken appointment fee of \$50 up to the amount of services scheduled.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that I received a copy of the Consent for Procedure/Payment of Fees.