PATIENT'S NAME ____

- I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE ABOVE NAMED PATIENT.
- I AUTHORIZE THE RELEASE OF MY DENTAL RECORDS (BY MAIL OR FAX TRANSMISSION) TO THE REFERRING OR FAMILY PHYSICIANS AS WELL AS TO MY INSURANCE COMPANY FOR CLAIMS PROCESSING IF APPLICABLE.
- I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED ARE DUE AT THE TIME OF SERVICE AND THAT INSURANCE TOTALS ARE ONLY AN ESTIMATE AND NOT A GUARANTEE.
- I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE BENEFITS AND TO NOTIFY THE OFFICE OF ANY CHANGES WITH MY INSURANCE COVERAGE.
- I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO DR. JOSEPH RUGGIRELLO FOR SERVICES RENDERED.
- I ACKNOWLEDGE THAT THERE IS A LATE NOTICE CANCELLATION AND FAILED APPOINTMENT POLICY. THERE MAY BE A CANCELLATION FEE OF $70 FOR APPOINTMENTS THAT ARE CANCELLED WITHIN 48 HOURS OF SCHEDULED APPOINTMENTS.
- I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT, FINANCIAL RESPOSIBILITY, RELEASE OF DENTAL INFORMATION, INSURANCE AUTHORIZATION, AND CANCELLATION POLICY.

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SIGNATURE OF PATIENT (OR PARENT IF MINOR) DATE