Easton Bright Smiles
Cosmetic & Family Dentistry

Consent of Services

Patient First Name_____Last Name_____DOB_____

As a condition of your treatment by this office, financial arrangements must be made in advance.
All co-payments are due at the time services are rendered.

Patients who carry dental insurance understand that payment for all services furnished are ultimately their responsibility. This office cannot render services on the assumption that our charges will be paid by an insurance company. As a courtesy to our patients, we will prepare and submit dental claims and assist in making collections from insurance companies. Any such collections will be credited to the patient's account.

In this office we believe in providing our patients with the utmost in care. This means using the best materials available in order to promote and preserve a healthy smile. We understand that your dental insurance may downgrade to amalgam (metal) fillings, however this is mercury-free office, and the patient is responsible for any difference in cost.

X-rays and Photographs

I authorize Easton Bright Smiles PC, the doctor, and team to take any x-rays and photographs deemed necessary for the detection and diagnosis of oral diseases. I authorize the release of this and any other information to my insurance company necessary for processing my dental claim (if applicable and according to HIPAA regulations)

Appointment of Policy

If you find it impossible to keep an appointment, for consideration of other patient's needs , we ask you to provide 48-hours notice.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay for services at the time they are rendered or within 5 days of billing, if credit is extended to me. Outstanding balances my be subject to additional charges. I further agree to pay all costs and reasonable attorney fees if my account has to be turned over to a third-party collection agency.

By checking here ( ) and signing below, I acknowledge that I have read and agree to the above terms of treatment.

X _____ Date: _____
(Signature of Patient or Responsible Party*)

*Responsbile Party – Relationship to Patient:_____