CONSENT FOR SERVICES

I understand that I am responsible for all charges incurred by me or a family member regardless of insurance coverage and **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.** If my account requires servicing by a collections agency or by an attorney, I understand that I will be liable for all collection fees, attorney fees and applicable court costs, in addition to my outstanding balance. I also request that payment under my dental insurance program be made directly to Robert B Murfree, DDS, DBA Big Creek Family Dentistry on any unpaid bills for services. I authorize the release of any dental information necessary to process this and all future claims. The understood business policy is such that the patient and/or parent/guardian who requests treatment for the patient is responsible for all fees for services rendered.
I give Dr Murfree and his office staff permission to use such measures as deemed necessary in their professional judgment to render a diagnosis. This would include, but not limited to an oral examination, prescribed radiographs (x-rays), prophylaxis, fluoride treatment and other diagnostic aids. I have given an accurate report of my physical and mental health history. I have reported any prior allergic/unusual reactions, abnormal bleeding and other conditions related to my health and or physical conditions that my medical doctor has advised me to report to the dentist.

_____ HIPPA NOTIFICATION: I have read and understand the Notice of Privacy Practices for Big Creek Family Dentistry.

_____ I authorize Big Creek Family Dentistry to use my x-rays and/or dental photographs for learning purposes and/or social media. Any personal information such as name will be removed to protect your personal identity when using photos or x-rays.

_____ I authorize Big Creek Family Dentistry to treat my child in my absence if I do not attend the appointment by letting a designated person who brings them to sign the consent form on my behalf. I also understand Big Creek Family Dentistry cannot render services to a minor under 18 years old without a signed consent form. If my child will be attending the appointment by themselves I will let Big Creek Family Dentistry know in advance so that a consent form can be emailed to me. I will send the signed consent with my child who would be driving themselves or dropped off.

I acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give informed consent. I further understand that this consent shall remain in effect until terminated in writing by me.

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

_____ Date: _____ Relationship to patient: _____
Signature of guarantor of payment/responsible party

Broken Appointment Policy

Your scheduled appointment is reserved specifically for you. It is extremely important that all patients honor their reserved dental appointment. Failure to do so deprives other patients from receiving dental care in a timely fashion. We reserve the right to charge for appointments that are cancelled or broken without 48 hours notice. Any broken appointment charges will need to be taken care of before you will be able to reschedule for another appointment. We understand that emergencies arise unexpectedly, and we will carefully assess each instance before applying and broken appointment fees. The charge associated with our policy is to be paid within 30 days to prevent collection procedures. Multiple cancellations and broken appointments may result in dismissal from Big Creek Family Dentistry.

_____I, the undersigned, have read and understand the broken appointment policy. I agree to any fees that are charged, should I fail to keep an appointment.

_____I, the undersigned, do not agree with the broken appointment policy and I agree to pay for services in full in advance and I agree to have the insurance send me the payment.

_____
Signature of patient, parent or guardian

_____
Date

_____
Relationship to Patient