Michael A. Baiker, D.D.S., P.A.
240 Fourth Avenue
Indialantic, Fl 32903

CONSENT FOR CARE AND TREATMENT

I, the undersigned patient ("Patient") do hereby agree and give my consent to Michael A. Baiker D.D.S. P.A. ("Dentist"), its agents and assigns, to furnish dental care and treatment considered necessary and appropriate, in the Dentist's sole discretion, in diagnosing and treating my dental condition according to the following terms and conditions:

I hereby acknowledge and agree that all amounts due for services rendered by the Dentist on behalf of the Patient shall, at all times, remain the responsibility of the Patient.

In the event the Patient is covered by a dental insurance policy, the Dentist will invoice the insurance carrier solely as a courtesy to Patient. The Patient shall pay Dentist in full for services rendered at the time said services are rendered and any reimbursements received from the insurance carrier shall be paid directly to Patient. Likewise, in the event Patient receives a direct payment from Patient's carrier for services rendered by Dentist but not yet paid for, Patient shall immediately pay over or assign those funds to the Dentist.

The Dentist agrees to timely schedule Patients for appointments. The Dentist shall have the sole discretion to determine the appropriate time to schedule a Patient, including those times wherein a Patient expresses the need to meet with the Dentist on an expedited or urgent basis. The Patient acknowledges and agrees that there may be times the Dentist is unable to schedule Patient for an appointment and the Patient hereby holds the Dentist harmless for any and all consequences associated with the Dentist's inability to schedule said appointment.

The Patient acknowledges and agrees that it is necessary to fulfill his or her obligation to arrive at the Dentist's office fifteen (15) minutes prior to the scheduled appointment. It is the Patient's responsibility to cancel any appointments that Patient is unable to meet. The Dentist shall attempt to reschedule all properly canceled appointments. All cancellations shall be made at least twenty-four (24) hours prior to the scheduled time or the Patient shall pay to Dentist a fee of $45.00 dollars. The Dentist shall have the discretion to withhold dental services until said $45.00 dollars is paid in full.

MINOR CHILDREN:

A Parent, Guardian or Responsible Party shall execute this Consent for Care and Treatment on behalf of all minors, and by doing so, assumes the liability for services rendered. Any divorce or settlement agreement involving a minor child is not binding upon the Dentist.

AUTHORIZED DESIGNEE TO RECEIVE DENTAL RECORDS:

In addition to Patient, I designate_____ as an authorized party to request and receive copies of my dental records, including but not limited to, charts, records, x-rays and billing information. This designee shall retain this right until such time as I expressly revoke the right in writing and provide Dentist with a copy of the revocation.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, I will be responsible for all cost of collecting monies owed, including court costs, collection agency fees and all attorney fees and costs.

I HAVE READ THE ABOVE AND UNDERSTAND MY OBLIGATIONS

_____ _____

Patient/Responsible Party Date

AUTHORIZATION FOR RELEASE OF INFORMATION TO HEALTH INSURANCE COMPANY

I understand that it may be necessary for the Dentist to communicate, from time to time, with my health or dental insurance company in connection with the processing of claims. I hereby consent to the release and disclosure, by the Dentist of all potential health or dental information to my insurance provider that may be requested by said carrier in the processing of my claim(s). I hereby consent to the release and disclosure, by the Dentist of all potential health or dental information to my insurance provider that may be requested by said carrier in the processing of my claim(s).

_____ _____

Patient/Responsible Party Date