Mukilteo Smiles
Stacey C. Sype, DDS, PLLC

Responsibility and Consent Statement

Patient: _____

I give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment.

I understand and acknowledge that I am financially responsible for the services provided for myself or the named above, regardless of insurance coverage.

For your convenience, we will submit your insurance claims but you are ultimately responsible for your own account balance. Most insurance companies do not cover 100% of all services; therefore **your "estimated" portion is due at time of service**. Please be aware if any portion of your claim is denied, you are responsible for the balance. Please monitor your monthly statement and notify us promptly if insurance payments have not been applied to your account within 45 days.

To better serve our patients we accept **cash, personal check, Visa, MasterCard and Discover**. **Care Credit** financing is available upon approval offering no interest and extended payment plans with low interest. There is a $37 charge for any returned check.

To better utilize time available for patient care, we require 48 hours notice for appointment changes or cancellations. Broken or changed appointments without proper notice are subject to a $25 per ½ hour of reserved appointment time.

_____ _____
Signature **Date**

If this Consent is signed by a guardian on behalf of patient, please complete the following:

Guardian's Name: _____

Relationship to Patient: _____