Patient Treatment Consent

Chart No

I authorize Arundel Mills Dental Group (including all affiliated Corporations, associates, or independent contractors), its dentist(s), and designated staff to perform all diagnosis and administer any treatment, procedure, and anesthesia necessary to render services that may be required or advisable to address my (i.e., the patient's) dental needs. I assign all dental insurance benefits to which I am entitled by my dental insurance policy to Arundel Mills Dental Group. This form also authorizes Arundel Mills Dental Group to submit insurance claim forms and receive payment directly from my insurance carrier with the notation "Signature on File." I authorize my Dentist(s) to release treatment records, radiographs, and any other information requested by my insurance company to facilitate payment. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents. I agree that any claims that my insurance carrier does not pay or any balance that extends beyond 60 days from the date of treatment may be assessed a service charge of 2% per month.

Print Patient Name	Patient or Parent/Guardian's Signature	Date