



Patient Consent

I understand that all responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2 % finance charge (18% APR) will be added to my account, in addition to any collection charges.

I understand that, in the cases of divorced families, the law considers the parent who brings the child to the appointment to be the responsible party.

I understand that it is my responsibility to advise Dr. Verdinelli's office of any changes in the information obtained in the forms I have filled out today as a new patient to this office.

I authorize the use of the social security number to file my dental claims.

I agree to the receipt of automated appointment notifications via text or phone.

I consent to the use of photographs, radiographs and case history for educational purposes in schools, website and internet use in connection with Sharon M. Verdinelli, DMD. I relinquish any and all rights to photographs captured via digital camera for use by Dr. Verdinelli.

Patient _____ Date _____

Patient or Responsible Party _____

Relationship to Patient _____

Witness _____