Western Maryland Dentistry

David S. Hijab, D.D.S., P.A.
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Consent for Treatment & Assignment of Benefits

I hereby give my consent for dental treatment to be performed on _____.
Patient Name (Please Print)

In the event I have insurance, I hereby assign benefits to be paid directly to *David S. Hijab, D.D.S., P.A.* on the above named patient.

_____
Patient, Parent, or Guardian Signature Date

Written Financial Policy

Payment Options:

You can choose from:

- Cash, Check, Visa, or MasterCard
- Convenient Monthly Payment Options* from CareCredit Healthcare Credit Card
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

David S. Hijab, D.D.S., P.A. requires payment when services are rendered including any estimated co-payments and deductibles if the above named patient has dental insurance.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.**

A fee of $25 may be charged for patients who miss or cancel appointments without 24-hour notice.

There is a charge of $35.00 for returned checks.

In the event of non-payment of an account, you may be assessed additional finance and/or billing charges. If the account is submitted to our collection agency, additional collection agency fees will apply.

_____
Patient, Parent, or Guardian Signature Date

*Subject to credit approval
**However, if we do not receive payment from your insurance carrier within 180 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.