CORNERSTONE
DENTAL GROUP

Ronald J. Solomon, D.D.S.
Angela Ott, D.D.S.

Financial Responsibility Agreement
Authorization for Treatment

I hereby agree that I am financially responsible for any and all charges that the patient named below incurs during the course of treatment with Cornerstone Dental Group. I understand that if I have dental insurance, my dental insurance is a contract between the insurance carrier and me and not between me and Cornerstone Dental Group, and that I am still fully responsible for all dental fees.

I understand and acknowledge that all fees are due and payable at the time the services are rendered unless prior financial arrangements have been made.

I also assign all insurance benefits to the Doctor and Cornerstone Dental Group. I further understand that a late charge of 1 ½% (18 APR) may be added to my account after sixty (60) days.

I also hereby acknowledge and agree that at least twenty-four (24) hours notice is required to cancel any appointment without incurring broken appointment charges of $50.00 for each half-hour broken appointment with hygiene and $75.00 for each half-hour with the dentist.

I hereby authorize the Dentist or designated staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Dentist to make a thorough diagnosis. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I understand that I may ask questions for clarification.

Child's name if patient is a minor_____

Signature _____ **Date:** _____