CREATIVE DENTAL CONCEPTS OF CNY, PLLC.
1000 East Genesee Street, Suite 401
Syracuse, NY 13210
(315) 475-6641

AGREEMENT

PATIENT_______________________________________ DATE OF BIRTH______________

RESPONSIBLE PARTY____

ADDRESS____

CITY, STATE, ZIP CODE____

THE UNDERSIGNED HEREBY CONSENTS TO EXAMINATION AND TREATMENT BY **CREATIVE DENTAL CONCEPTS OF CNY, PLLC.** I AUTHORIZE THE RELEASE OF DENTAL RECORDS TO MY INSURANCE COMPANIES FOR THE PURPOSE OF SECURING PAYMENT AND FOR THE QUALITY ASSURANCE REVIEW AS REQUIRED BY LAW. I AUTHORIZE RELEASE OF DENTAL RECORDS TO DENTISTS CONSULTING ON MY CARE. I AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO **CREATIVE DENTAL CONCEPTS OF CNY, PLLC.** I AM AWARE THAT I AM RESPONSIBLE FOR ANY PORTION WHICH IS DENIED OR OTHERWISE NOT COVERED BY INSURANCE UNLESS LAW OR CONTRACT BETWEEN MY DENTIST AND MY INSURER PROHIBITS SUCH RESPONSIBILITY.

IN THTE EVENT I DEFAULT ON PAYMENT OF ANY BILL OR PORTION OF ANY BILL ISSUED BY OR ON BEHALF OF **CREATIVE DENTAL CONCEPTS OF CNY, PLLC.** I AGREE TO PAY ALL COLLECTION COSTS ASSOCIATED WITH COLLECTING SAID DEBT, INCLUDING BUT NOT LIMITED TO ATTORNEYS FEES OF 25% (TWENTY FIVE PERCENT), TOGETHER WITH COSTS AND DISBURSEMENTS.

____ ________________________________
Signature of Patient, Parent, or POA Date

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Print Name of Signer and Relationship