Richard L. Lachenmayr, D. M.D
1150 Third Avenue, Suite 2
Alpha, NJ 08865

Consent and Financial Policy:

1. The undersigned hereby authorizes the doctor to order x-rays, study models, photographs, or any other diagnosis aids deemed appropriate by doctor to make a thorough diagnosis of the patients dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for 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. I understand that any portion not covered by my insurance is my responsibility. In the event payments are not received by the agreed upon dates, I understand that a 1 ½ % **FINANCE CHARGE** (18% APR) may be added to my account in addition to any collection charges.
4. I understand that there is a $25.00 fee for returned checks.
5. I understand that where appropriate, credit bureau reports may be obtained.
6. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
7. I authorize the use of my signature and social security number to file my dental claim, if no ID# was assigned by the insurance company. I release and assign my benefits to Richard Lachenmayr, D.M.D
8. I understand that this office is out of network with most insurance companies. Any patient that has **Blue Cross Blue Shield** will receive the payments for the services rendered in this office. Any payments I receive are to be cashed and a check or credit card payment made to Dr. Lachenmayr along with the remaining balance in a timely manner or my account will be turned over to a collection agency.
9. If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of a balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Warren County, New Jersey.

Patient Signature: _____Date:_____

Parent or Responsible Party: _____

Relationship to Patient:_____Date:_____