Laura Y. Ki, D.D.S., PC
4001 Fair Ridge Drive, Suite 205, Fairfax, VA 22033
Phone: 703-273-2545 Fax: 703-273-1116

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without pervious financial arrangements, must be paid for in cash at the time services are performed.

Our office will help prepare the patients dental insurance forms or assist in making collections from their insurance companies and will credit any such collections to the patient's account. However, **this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Patients who carry dental insurance understand that he or she is personally responsible for payment of all services thereafter.**

A service charge of 1.5% per month (**18**% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by Dr. Ki, I agree to pay therefore the reasonable value of said services to said Dr. Ki, or her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ **Date:** _____ **Relationship to Patient:** _____
Signature of patient, parent or guardian:

_____**Date:** _____ **Relationship to Patient:** _____
Signature of guarantor of payment/responsible party

****We reserve the right to charge $40 per 30 minutes for Broken Appointments without 48 hours notice****