



Our accent is on Your Smile!
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Phone: 573.446.7181 | Fax: 573.446.1770

I, the undersigned, grant permission to any physician, dentist, clinic or hospital to release to Accent Dental Center on Forum, all information concerning my present and/or past medical or dental condition and treatments.

FINANCIAL AGREEMENT: I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees, and any other charges incurred in the collection of any balance due. I further understand that a fee of **35%** will be added to my total account balance in accordance with this facility's contract with its collection agency.

Appointment scheduling conflict policy: I understand that if I do not give a 2 business day notice for any scheduling conflict, my account may be charged a cancellation fee of \$25 per reserved hour.

Patient/Guardian: _____

Date: _____