BROWN-McMULLEN-WISSE DENTAL ASSOCIATES

316 WEST FOURTH STREET
QUARRYVILLE, PA 17566
www.quarryvilledentist.com

PATIENT NAME: _____

RESPONSIBLE PARTIES WHOSE SIGNATURES APPEAR BELOW AGREE AS FOLLOWS:

- The Doctors and Staff of Brown-McMullen-Wisse Dental Associates, hereafter referred to as BMWDA, are authorized to dentally treat the patient named on this form and to exchange past, present, and future dental information with the patient's other dental/medical caregivers for the purpose of enhancing and promoting the continuity of care for the patient.
- The Responsible Parties agree to pay for all fees and charges for supplies, services, and treatment that are incurred by the patient per the terms of this agreement. All charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. The Responsible Parties remain, jointly and severally, financially responsible for the patient until BMWDA receives notification in writing to the contrary. If the patient is currently a minor, the Responsible Parties guarantee is continuing even after the patient reaches the age of maturity.
- Not all services and/or fees are covered by the benefits plan of the Responsible Parties' dental plan insurance, hereafter referred to as the PLAN. Therefore, the Responsible Parties agree to pay for all deductibles, co-payments, non-covered services and any portion of covered services not paid in full by the PLAN and understand that such payments are due at the time of service or immediately upon presentation of the bill.
- If any account balance should remain unpaid after 90 days and BMWDA refers the account to a collection agency for collection, the Responsible Parties agree to pay the costs of collection and that such fees and costs may be added to the account balance.
- Payments will not be delayed or withheld. All proceeds from the PLAN are assigned to BMWDA where applicable. As they are responsible for all charges the Responsible Parties will assist BMWDA in every way to collect payment from the PLAN to the extent their help is required.
- The Responsible Parties agree to pay $25.00 for missed appointments, or those cancelled within 24 hours of appointment time.

AGREED TO AND ACCEPTED BY THE RESPONSIBLE PARTIES:

X_____ date: _____
(signature of Responsible Party, Parent, or Guarantor)

(print name) _____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my protected health information (PHI*) be discussed by Brown-McMullen-Wisse Dental Associates with the following individuals: (*PHI includes such things as dental & medical history, treatment/treatment plans, appointments)
___ NO ONE EXCEPT MYSELF

Please print names: (examples: husband/wife, mother/father, children, POA)
_____ relationship: _____
_____ relationship: _____
_____ relationship: _____

Patient Signature: _____ date: _____

(print name) _____