Robison Associates P.C.
3235 Templeton Gap Road
Colorado Springs, CO 80907
719-630-7727

Date: _____

Subject: Patient Consent and Office Financial Policy

I, _____, hereby authorize Dr. Robison to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Robison to make a thorough diagnosis of my dental needs. I also authorize Dr. Robison to perform treatment, prescribe medication, and therapy that may be deemed necessary and that has been explained to me.

I understand the use of anesthetic agents embodies a certain risk.

I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and Dr. Robison and that I am still totally responsible for all dental fees. These fees are due and payable at the time services are rendered and payable by cash, check, VISA, Mastercard, American Express, or Discover Card. I also assign all insurance benefits to Dr. Robison. Any payments received by Dr. Robison from my insurance carrier will be credited to my account, or refunded to me if I have paid the dental fees incurred.

I further understand that a billing charge of $10 will be added to any balance that is over 30 days or more old (60 days for insurance accounts). This charge will be added to the account each billing period until the account is paid. If a check is returned to Dr. Robison for insufficient funds, closed account, etc., a $25 fee in addition to any bank charges will be assessed to the account. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

I understand there will be a charge for each broken appointment of $52.00 if 48 hours notice is not given (with the exception of emergencies).

I understand that an estimate of any dental treatment required is guaranteed for only 90 days from the date the estimate is given.

Patient Signature (Parent of Child): _____
Date: _____

Dentist Signature: _____