EDWARDS
ORTHODONTICS

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RE: PT. NAME:_____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of myself or a minor/child, as applicable. I accept full financial responsibility for all charges for services or items provided to the above patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

I assign directly to Dr. Cory Edwards all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. It is my responsibility to notify Dr. Edwards' office if the insurance company or status changes for any reason.

Edwards Orthodontics may use the above patient's health care information and may disclose such information to the Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits.

_____ _____
Patient Signature/ (Parent or legal guardian if patient is a minor) Date

PHOTO RELEASE

Dr. Edwards may wish to use the above patient's orthodontic images for brochures, case presentations or other practice-related applications. No names will be used. These images will not be used for any other purposes. I, the undersigned, do hereby understand and give my permission for Dr. Edwards to use any and all images for the above-stated purposes.

_____ _____
Patient Signature/ (Parent or legal guardian if patient is a minor) Date

IF THE ABOVE PATIENT IS A MINOR OR DEPENDENT:

I am the parent, guardian, or personal representative of the above named patient and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize Dr. Edwards and/ or his staff to perform necessary orthodontic services for the child named above, including but not limited to x-rays, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

_____ _____
Parent or legal guardian signature Date