Coonen Dental
3060 Cabernet Dr. Ste #1, Helena, MT 59601
Phone: (406) 442-3190

Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may indicated. I authorize and consent that the doctor employ any such assistance as he deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others who may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the preactive for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

_____Date_____
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Patient signature/legally authorized representative

_____Relationship_____
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Printed name if signed on behalf of the patient

Insurance agreement

I certify that the preceding insurance information is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filling of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and me. I understand that an estimated portion is due at the time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed, by my insurance company, I understand that my portion may be more if my insurance company doesn't pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

_____Date_____
__
Patient signature/legally authorized representative