Mark R. Zemanovich, D.D.S., P.C.
Practice Limited to Periodontics and Implantology

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CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

Consultation fees are always due at consultation visits. We are always glad to file with your insurance so you may be reimbursed directly from your company.

1. I hereby authorize Dr. Zemanovich or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my or my dependent's needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications of all procedures to be performed.

4. I agree to be responsible for payment of **all** services rendered on my behalf or my dependent's regardless of insurance coverage. I understand that payment is due **at the time** of service unless other arrangements have been made prior. In the event payments are not received by agreed upon dates, I understand that a 1.5% finance late charge (18% APR) may be added to my account.

5. I agree to give **at least 24 hours** of notice before rescheduling or cancelling an appointment. I understand that failing to provide at least 24 hours of notice could result in a fee of $50.

6. Lastly, in the event that any unpaid accounts are turned over to an attorney for collection, I agree that jurisdiction for said collection shall be Frederick County, Virginia; that I shall pay all reasonable costs of collection, including attorney's fees of 33 1/3%, court costs and other collection fees. I also waive the benefit of all homestead or other exemption as to the collection of my account.

Patient: _____ **Date:**_____

Responsible Party for Payment: _____

Relationship of Responsible Party to Patient: _____