Authorization / Release:

AS A CONDITION OF YOUR TREATMENT BY THIS OFFICE, FINANCIAL ARRANGEMENTS MUST BE MADE IN ADVANCE. THE PRACTICE DEPENDS UPON REIMBURSEMENT FROM THE PATIENTS FOR THE COSTS INCURRED IN THEIR CARE AND FINANCIAL RESPONSIBILITY ON THE PART OF EACH PATIENT MUST BE DETERMINED BEFORE TREATMENT. ALL EMERGENCY DENTAL SERVICES, OR ANY DENTAL SERVICES PERFORMED WITH OUT PREVIOUS FINANCIAL ARRANGEMENTS, MUST BE PAID FOR AT THE TIME SERVICES ARE PERFORMED. PATIENTS WHO CARRY DENTAL INSURANCE UNDERSTAND THAT ALL DENTAL SERVICES ARE, AS A COURTESY, SUBMITTED TO YOUR INSURANCE. THE PATIENT IS RESPONSIBLE FOR PAYMENT AT THE TIME OF THE SERVICE. THIS DENTAL OFFICE CAN NOT RENDER SERVICES ON THE ASSUMPTION THAT OUR CHARGES WILL BE PAID BY THE INSURANCE COMPANY.

I UNDERSTAND THAT THE FEE ESTIMATE LISTED FOR THIS DENTAL CARE CAN ONLY BE EXTEDED FOR A PERIOD OF 30-DAYS FROM THE DATE OF THE PATIENT EXAMINATION. IN CONSIDERATION FOR THE PROFESSIONAL SERVICES RENDERED TO ME, OR AT MY REQUEST, BY THE DOCTOR, I AGREE TO PAY THE REASONALBE VALUE OF SERVICES TO THE DOCTOR, OR HIS ASSIGNEE, AT THE TIME SERVICES ARE RENDERED.

_____ ____/____/____

SIGNATURE OF PATIENT, PARENT OR GAURDIAN **DATE**

RELATIONSHIP TO PATIENT _____

_____ _____/_____/_____

SIGNATURE OF GUARANTOR OR RESPONSIBLE PARTY **DATE**

RELATIONSHIP TO PATIENT _____

Don J. Ilkka D.D.S. – 8301 CR 44, Leg A – Leesburg, FL 34788 352-787-4748