DAN M. HENRICKSEN D.D.S.

OFFICE POLICIES and CONSENT FOR TREATMENT

Welcome to our office. We want your visit with us to be as positive as possible. In order to keep things simple for everyone, please help us by adhering to the following policies:

Cancellations: Please call 24 hours in advance of your appointment if you have to reschedule your appointment . We understand that emergencies do arise and those will be taken into consideration. However, we reserve the right to charge up to $50 per hour if you fail to keep an appointment without proper notice.

Payment: While we are a provider listed with many dental insurance companies and are happy to bill them for you, we require the patient's portion of the bill be paid in full at the time of service. Due to the complicated nature of insurances, we may not be 100% accurate in the estimates at all times. Please be advised that should the insurance pay less than estimated, you are responsible for the remainder of the bill. In addition, if we over-estimate your co-pay, we will refund any credit after insurance has paid.

CONSENT FOR TREATMENT

I, the undersigned, hereby authorize the doctor to take x-rays, 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 have been mutually agreed upon. I authorize and consent that the doctor may employ any such assistance as he deems appropriate.

I further authorize the release of any information, including the diagnosis, x-rays and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that 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. I understand that a $25 service fee will be charged for any NSF check returned from the bank. Breach of this responsibility carries the penalty of compensating the practice 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.

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Signature of patient or Authorized responsible party	Relationship	Date