Office Policies / Signature on File

Financial Responsibility

I acknowledge that I am responsible for any balance on this account. In the event that my account becomes delinquent, I acknowledge that I am responsible for this debt, and for all fees necessary to collect this debt.

By signing this statement you agree to be financially responsible for all charges.

Patient/Guardian Signature _____ Date _____

Insurance Responsibility Statement

Your insurance is a method for this office to receive reimbursement for services rendered here. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not our office. It is your responsibility to pay for the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

By signing this you authorize payment of these benefits directly to Randolph L. Mitchell, DMD on your behalf for any services and materials furnished.

Patient/Guardian Signature _____ Date _____

X-Ray Policy

It is **our duty** to provide competent, comprehensive care, and radiographs are vital to proper diagnoses. Without the necessary images, we compromise our ability to provide this care. Regular X-rays are REQUIRED for every patient of this office at the ADA / FDA recommended intervals or at other times as deemed necessary for treatment.

If you choose to refuse recommended diagnostic radiographs, we have the responsibility to refuse to treat you –This is in your best interest as well as ours.

By signing this you state that you understand our office X-ray policy. If you continually refuse the recommended diagnostic X-rays the consequence is that you will dismissed as a patient of this office.

Patient/Guardian Signature _____ Date _____