**** For information only. You will sign an electronic copy at your 1st visit. This document is available at www.morgandental.net.****

Morgan Dental

Health Care and Consent to Treatment Agreement

We are pleased that you have chosen *Morgan Dental* for your dental needs. In order to better inform you, please read the following Health Care and Consent to Treatment Agreement. Posting of the current *Agreement* in effect on this website will serve to keep you informed of any changes in policy.

Consent to Treatment
I hereby consent to evaluation, diagnostic procedures, and treatment as directed by Dr. Morgan or authorized staff. I consent to photography, radiography, and digital images for treatment, evaluation, and to verify identity for payment purposes. I understand that by law Andrew A. Morgan, D.D.S. will retain ownership rights to such images as part of my patient chart but that I will be allowed access to view them and obtain copies.

Accidental Exposure of Health Care Worker
I understand that Texas Law provides and I give consent that in the event of healthcare worker is exposed to my blood or body fluids, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

Insurance
You, as the patient, are responsible for all charges regardless of insurance coverage. As a courtesy, *Morgan Dental* is happy to file claims with your **primary** insurance company for services rendered. Your deductible, co-payment, and/or co-insurance are due at the time of service. However, if we have not received payment from your insurance company within 45 days from the date of service, you will be expected to pay the balance in full. Secondary benefit claims will be filed on your behalf at your request and any monies due will be sent directly to you from your benefit plan or sent by check from this office if paid to us directly by your benefit plan. You have the right to restrict disclosure of treatment performed on you when you pay all treatment costs in full at the time of service.

Payment
We realize that patients have financial needs and we will do our best to find a solution that will work best for you. *Morgan Dental* accepts Visa, MasterCard, American Express, Discover, and personal checks with proper identification. We are unable to accept post-dated checks. Returned checks may be recovered electronically along with state allowed recovery fee. Third party financing through Citi Health Financing (payment plans) is also available with approved credit. Payment of co-insurance, deductible, and/or co-payment is required at the time services are rendered. Patients with outstanding balances 30 days or more overdue must make arrangements for payment prior to scheduling future appointments.

Missed Appointments/ Late cancellations
Your appointment is time set aside especially for you. Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time reserved for you. **Please call our office and speak to an appointment coordinator 1 business day prior to your appointment if you must cancel or reschedule**. Unfortunately, if the required notice is not given, a fee of $40 per half hour will be charged and immediately payable. Excessive abuse of this policy may result in discharge from the practice.

Treatment Deposit
If dental treatment is needed, we request a payment deposit equal to 50% of your estimated co-payment but no less than $75 before scheduling your appointment if over 60 minutes or at our discretion. This deposit will be applied to your dental treatment co-payment provided that your appointment is kept or is rescheduled and/or cancelled with 1 business day's notice. Failure to give a business day's notice of cancellation or the need to reschedule will result in forfeiture of your entire deposit.

Signature on File
I hereby authorize the office of Andrew A. Morgan, D.D.S. to affix my name to any and all claims or documents as related to any and all health benefits due to me or my dependents through my employment. I agree to be responsible **for all charges for dental services and materials not paid by my dental benefit plan**, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information related to this claim.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Andrew A. Morgan, D.D.S., P.A. This "Signature on File" will be valid from this date. A photocopy or scan of this document may act as the original. I also agree that should it become necessary to forward my account for collection proceedings, in addition to the amount owed, I will also be responsible for the fees associated with the costs of collection.

I have read and understand the *Morgan Dental* Health Care and Consent to Treat Agreement.

Signature

Witness

Name of Signer

Name of Witness