Disclaimer and Release

I voluntary and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but are not limited to, radiographs (x-rays), study models, imagery, photography and other aids. All new patients require panoramic radiographs with possible other radiographs as needed, and all existing patients require updated radiographs per the following schedule: one full mouth radiograph / panoramic radiograph once every three years; bite wing radiographs once every year; and single / multiple intraoral radiographs as medically necessary. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me. These may include, but are not limited to: partial or complete temporary or permanent Paresthesia (numbness that remains), hypersensitivity and allergic reactions, shortness of breath, hematoma, swelling, pain, toxicity, death. See **Complications following local anesthesia** for more detail (available at the front desk).

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others within the dental practice. All returned checks will be subject to a $100.00 returned check fee. **Appointments missed or canceled within 24 hours prior to the scheduled appointment time will result in a fee of $75 per appointment.** If I am more than 10 minutes late to my scheduled appointment, I may not be seen by the dentist. **Any account balances that remain unpaid for 30 days from the date of service will incur a $35.00 per month billing charge.** Any overdue balance may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for all collection costs with a minumum of $100.00. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree to also be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimilie, email or phone number (whether a cellular telephone or landline) that I provide to the dental office or any agent of the dental office.

For patients with insurance or managed care:

I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize myinsurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith. In addition, I authorize Nanditha Ranganathan, DDS dba Dentistry at Millennium Park to disclose any and all written information from the patient's Insurance Company and/or its designated representatives. Such disclosure shall be for reimbursement purposes for those services received. I hereby release Nanditha Ranganathan, DDS dba Dentistry at Millennium Park, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the patient's Insurance company(s) or their designated representatives.

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I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, by spouse and/or my employer. The dentist is NOT a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, **I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me.** As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist (30 days after Claim is sent from this office).

I assign my right to receive payment of authorized benefits to Nanditha Ranganathan, DDS dba Dentistry at Millennium Park. I request that payment of authorized benefits be made on my behalf Nanditha Ranganathan, DDS dba Dentistry at Millennium Park for any services furnished the patient listed above provided by Nanditha Ranganathan, DDS and onsite health care providers. I authorize Nanditha Ranganathan, DDS dba Dentistry at Millennium Park to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my Dental and/or Medical Insurance Plan will not direct payment to Nanditha Ranganathan, DDS dba Dentistry at Millennium Park, I agree to forward to Nanditha Ranganathan, DDS dba Dentistry at Millennium Park ALL Insurance Payments which I received for the services rendered at Dentistry at Millennium Park**. I agree that I am responsible for all charges for services provided to the patient which are not covered or paid by my Insurance Plan or for which I am responsible for payment under my Insurance Plan. If my insurance denies any performed treatment for any reason, I will be responsible for payment in full to Nanditha Ranganathan, DDS dba Dentistry at Millennium Park. I further agree that, where permissible by law, I will reimburse Nanditha Ranganathan, DDS dba Dentistry at Millennium Park for all costs, expenses and attorney's fees that may be incurred by Nanditha Ranganathan DDS dba Dentistry at Millennium Park to collect those charges.**

I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care complete information and any changes thereto, and to give immediate notification of any changes in this coverage. I understand that this form applies and extends to subsequent visits and appointments at Dentistry at Millennium Park.

You are entitled to a copy of this form, which may be issued to you at the front desk upon your request.

Print Patient Name:_____

Patient / Guardian Signature:_____ Date:____/____/_____