**Dr. Daniel Thrall, DDS**
**305 Northridge Circle**
**Guymon, OK 73942**

Patient Name:_____

## Statement of Financial Policy

**Terms and Conditions**: I understand that full payment is customary at the time of treatment. All emergencies will be on a cash basis only. If I carry insurance, this office will prepare the forms for my insurance carrier; however, I am responsible for any balance after 60 days. I agree to reimburse this office the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorney' fees, I incur in such collection efforts.

Signed:_____Date:_____
(Signature of responsible party)

## Consent Information

**Consent for Treatment**: I understand that the information that was given today is correct to the best of my knowledge. Too, I understand this information will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. I authorize this dental staff to perform any necessary dental services with informed consent that I may need during diagnosis and treatment. I understand that during treatment it may be necessary to change or add procedures for conditions found while working on the teeth that were discovered during examination, the most common being root canal therapy following routine restorative procedure(s). I give my permission to make any/all changes, additions necessary.

Signed: _____Date:_____

## Acknowledgement of Notice of Privacy Practices

I, _____, have been shown and been given full opportunity to read and consider the contents of this office's Consent form and Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to this office's use and disclosure of my protected health information to carry out treatment, payment, activities, and health care operations.

Signed:_____Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal representative's name:_____

Relationship to Patient:_____