Best Dental Care NJ, LLC
40 Park Place, Suite 108
Newton, NJ 07860
973-383-5700

Consent for Care and Treatment:

I, the undersigned, do hereby agree and give my consent for Best Dental Care NJ, LLC/Marlayna C Best DMD LLC to furnish dental care and treatment to_____
Considered necessary and proper in diagnosing or treating his or her oral condition.

Patient/Guardian_____

Date_____

Benefit Assignment/Release of Information:
I hereby assign all dental and/or surgical benefits to include major medical benefits which I am entitled, including Medicare, private insurance, and any other health plans to Best Dental Care NJ,LLC/Marlayna Best, DMD LLC. A photocopy of this assignment is considered to be as valid as the original. I hereby authorize said assignee to release all information necessary including medical records, to secure payment.

Patient/Guardian_____

Date_____

Financial Policy Statement:

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment with 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to Best Dental Care NJ, LLC/Marlayna Best DMD LLC.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised that as a Compensation patient you may be held responsible for your charges in the event that your claim in converted.

In addition I will be charged $50.00 per each ½ hour of a no show, no call & no 24 hour notice for a missed appointment.

For all restorative and periodontal treatment appointments, I will be required to prepay my portion to get an appointment.

I understand and agree if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Best Dental Care NJ, LLC/Marlayna Best, DMD I will be responsible for all costs of collecting monies owed including interest, court fees, collection agency fees and attorney fees

The above information has been read and explained to me. **I understand my responsibility for the payment of my account.**

Patient/Guardian_____

Date_____