RELEASE AND AUTHORIZATION FOR TREATMENT

Dr. Ali Sarkarzadeh
Congressional Dental Care
1750 Rockville Pike, Rockville MD, 20852
P: 301-770-5400
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1. I understand that there are no treatment guarantees.
2. I understand that my medical / dental situation can change, thus affecting the outcome.
3. I understand that all radiographs (x-rays), models, and any other diagnostic materials are the property of Congressional Dental Care and will be used by the Practice accordingly.
4. As a patient I am entitled to a copy of my X-rays for a fee upon written request.
5. I understand that there are health risks, although minimal, involved with any dental treatment.
6. I understand that even though I may have dental insurance, the ultimate responsibility for payment is mine. After a 90 day period, payment is due in full unless prior arrangements have been made.
7. If I miss a Hygiene appointment, or give less than a 2 business day notice for a cancellation or rescheduling, there will be a $50.00 fee assessed to my account or the credit card on file.
8. I authorize my dental insurance company to pay Congressional Dental Care directly.
9. I understand that if I do not pay my bill in a timely manner, late fees and finance charges will accrue. If the services of a collection agency are required, that fee will also, be my responsibility.
10. In the case of a divorce, it is the parent who makes the appointment or accompanies the child that is responsible for payment for dental services rendered.

My signature below constitutes my agreement to the above statements and authorizes the Hygiene Cancelation fee to be assessed to my credit card.
Card Type__________Card Number_________________________________Exp_________CVV code__________
Patient signature Parent / guardian for minor under age 18

VITAL INFORMATION ABOUT YOUR DENTAL INSURANCE
As a courtesy to our patients, our office will:
Complete your insurance claim form and submit them to your carrier for you with proper documentation included.
ϖ Accept direct payment from insurance carriers
ϖ Use current ADA coding for correct reporting of procedures.
ϖ If necessary, re-file your claim for a second time within a 45 day period. Your responsibilities as a patient:
ϖ Pay fees not covered by your plan at time of treatment.
ϖ Provide our office with the necessary information concerning your insurance coverage to allow correct filing of claims.
ϖ Understand that your plan is a contract between you, your employer, and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay.
ϖ Pay any account balance not paid by insurance in 90 days.

Patient or Insured__________________________ Date________________________
Guardian Signature_________________________