PROSTHODONTIC ASSOCIATES OF NEW JERSEY, PA

98 James Street, Suite 303

Edison, NJ 08820

# PAYMENT CONSENT FORM FOR DENTAL TREATMENT SERVICES

Print Patient Full Legal Name

Print Partner Full Legal Name

I/We have been counseled by PA of New Jersey finance department, regarding the financial requirements of our dental services as follows:

We Acknowledge and accept full financial responsibility for all charges incurred as a result of undergoing Dental Services, in the event of our dental Insurance policy does not cover these services.

We acknowledge that the Fee Schedule presented to us at the time of we entered this program is an Estimated Fee Schedule. Charges may change without notice and vary depending on our individual situation.

We acknowledge and accept that PA of New Jersey, PA requires that all non-covered services be paid in full prior to beginning dental treatment services. We have been informed that payment by cash check or credit card (PA accepts American Express, Visa, MasterCard and Discover card) must be made at least two weeks (2) prior to the start of treatment.

We acknowledge that charges and payments for procedures performed are non-refundable.

We acknowledge that we are financially responsible for all non-covered or excluded charges under the terms of our dental insurance contract even in the event that PA of New Jersey, PA has a participating dentist contract with our health insurance carrier.

PA of New Jersey, PA

Patient

Date

Partner