BERKSHIRE DENTAL ASSOCIATES, LTD

1260 Broadcasting Road, Suite 100
Wyomissing, PA 19610
610-376-3210

Robert J. Shuttlesworth, D.D.S., M.S.
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CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct. I understand that it is my responsibility to inform my doctor of any changes in my health or my minor child.

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of ______________________________

Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

INSURANCE ASSIGNMENT AND RELEASE

I certify that myself along with my dependent(s)are covered by insurance with______________________________

Name of Insurance Company(ies)

and assign directly to Dr. ______________________________ all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use mine and my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

FINANCIAL AGREEMENT

I acknowledge that I have received and understand a copy of the financial policy of Berkshire Dental Associates, LTD. I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment for myself and/or child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

______________________________ ______________________________

Signature of Patient, Parent, Guardian or Personal Representative **Date**

______________________________ ______________________________

Please print name of Patient, Parent, Guardian or Personal Representative **Relationship to Patient**