



St. James Dental Care, PLLC

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CONSENT FOR TREATMENT FINANCIAL AGREEMENT

As a patient in this office, I understand that I am financially responsible for costs incurred in my dental care and that payment for my dental care rendered.

Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of these services. Our office will submit your insurance forms and credit any insurance payment to your account. However, this office cannot render services on the assumptions that our fees will be paid by your insurance company.

I further understand that an estimate for treatment can only be extended for a period of 6 months from the date of examination.

I understand that a service charge of 1 1/2% per month (18% per annum) will be applied if my unpaid balance exceeds 60 days.

Forty Eight Hours Notice –needed for appointment cancellation – if not a cancellation fee may be charged.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignees, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable fees if a suit be instituted hereunder.

I grant my permission to you or your assignees, to telephone me at home or at my work to discuss matters related to this form.

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT / PAYMENT AND I AGREE TO THERE CONTENT.

Signature of Patient, Parent or Guardian

Relationship to Patient

Date