Robert L. Bradbury, D.M.D.
Anthony V. Amato, D.M.D.
18 North Main St.
West Hartford, Connecticut 06107
860-561-3050 FAX: 860-561-5312

Consent to Treatment
I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. **I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.**

X_____
Signature of patient or parent if minor **Date**

Authorization, Release, and Agreement to pay For Services Rendered
I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that if my dental insurance carrier pays less than the actual amount for services, I will be responsible for the balance of all services rendered on my behalf or on behalf of my dependents. If the services are NOT covered by my insurance, I will be responsible for the usual & customary fees for those services.

X_____
Signature of patient or parent if minor **Date**

Late Charges
Payment in full is requested at the time of service. If I do not pay the entire new balance within 60 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

X_____
Signature of patient or parent if minor **Date**

In case of emergency, contact (If possible, someone who does not live in your household.)

Name_____ **Relationship**_____

Home Phone_____ **Work Phone**_____