MICHAEL AIELLO, D.D.S.

Dentistry in a Relaxed & Caring Atmosphere

Responsibility and Consent Statement

I, __________________, give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment. This may include study models, photographs, and x-rays.

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage. We will do our best to help you utilize your insurance benefits. Your insurance carrier decides the ultimate decision in payment. All insurance coverage portions are estimates. We request that fees for services, deductibles, and co-pays should be paid at the time that services are rendered.

I also understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment, and its fee.

I understand that balances are due at the time of service unless other signed financial arrangements have been made. Accounts 60 days past due will be subject to a 1.5% service charge.

I understand that a fee will be charged for each missed appointment.

Patient/Guardian Signature______________________________Date________

Office Representative Signature__________________________Date________

43630 Hayes Rd. Suite 230 Clinton Township, MI 48038 586-263-6800