J. Randall Kornegay, D.M.D.
711 Kornegay Drive, Suite B
Prattville, AL 36066
334-285-3070

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also understand that all Co-Pay fees quoted are only an **ESTIMATE**. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred.

I further understand that a finance and/or late charge may be added to any overdue balance. I understand that where appropriate, credit reports may be obtained and that I am responsible for all collection agency fees (33.33%), attorney fees, and court costs if incurred. I agree, in order to service my account or collect monies owed, J. Randall Kornegay, DMD and/or agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. You may also contact me by sending text messages or emails, using any email address I have provided. I understand methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

INSURANCE AUTHORIZATION

***As a courtesy to our patients, we are happy to file your dental claims at no charge. It is NOT a guarantee of payment!

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the named dentist or dental entity.

NOTICE

Please note that there may be an administrative fee of $50 for any appointment cancelled or broken (no show) without a 48 hour notice.

Our Practice believes that a good doctor/patient relationship is based upon understanding and good communication. Thank you for being a valued patient. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

X _____

Signature Date