

**Advance Dental Center  
Dr. Bill Burgess ~ Dr. Louis Burgess  
8159 Walnut Grove Road Cordova, TN 38018  
Tel: 901.756.8111 Fax: 901.756.8171 burgessdental.net**

Patient Registration and Consent for Medical Treatment

Please initial each section:

**Consent for Dental Care Services:** I authorize consent for dental treatment at Walnut Grove Woods Dental Office . \_\_\_\_\_

**Authorization for Release of Information:** Walnut Grove Woods Dental Office, may release information from my dental records to any health care provider involved in my care and treatment. Walnut Grove Woods Dental Office may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of dental records information to an insurance company or other payer pursuant to this authorization, Walnut Grove Woods Dental Office, is no longer responsible for the confidentiality of any information known or possessed by the payer. \_\_\_\_\_

**Financial Agreement:** I understand I am responsible for the payment and/co-payment that is due at the time of service. I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Walnut Grove Woods Dental Office, which are not paid by my dental insurance or other payer. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to responsible party and address on file with Walnut Grove Woods Dental Office. I understand that I am responsible for a \$30.00 returned check fee in addition to any other associated bank charges. \_\_\_\_\_

**Payment Arrangements for Your Convenience:**

- (1) A 5% discount for payment in full at time of treatment with cash or check.
- (2) We accept Visa, MasterCard or Discover
- (3) 3, 6, or 12 month payment plan upon approved credit through Chase Health Financial.  
These are non interest bearing accounts.

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**Signature of Patient or Legally Responsible Person**

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**Print Name**

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**Date**

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**Charge for No Show/Cancellation without 24 hour notice:** I understand that I will be charged a \$50.00 fee for appointments that are missed/broken. We ask that you cancel/reschedule 24 hours prior to the scheduled appointment. I also understand that I will be responsible for this charge and that my insurance company will not pay for cancellation/no show fees. \_\_\_\_\_

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**Signature of Patient or Legally Responsible Person**

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**Print Name**

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**Date**