Consent for Treatment

To patients who seek dental treatment in our office, please read the following and sign that you acknowledge at the bottom of the page:

1. I assign dental benefit payments to be paid directly to the office of Dr. Adam F. Lukens from my insurance company.

2. I understand that my insurance is an arrangement between me and my insurance company. I also understand that I am responsible for any remaining balance my insurance does not cover.

3. I understand there may be a $45.00 charge if I cancel or fail an appointment with less than 24 hours notice.

4. My account will incur a finance charge of 1.5% per month or 18% per year if my balance is not paid in full at 30 days following the date of treatment completion.

5. I understand service fees presented in my treatment estimate will be honored for a period of 90 days from the date which the treatment estimate was presented.

6. I give permission for Dr. Lukens and his clinical team to take any necessary x-rays, photos, or study models to enable complete diagnosis and treatment.

Signature of Patient or Patient's Guardian:

_____Date:_____

Adam F. Lukens, D.D.S.
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