Dr. Purnima Hernandez & Dr. Selin Soyupak
23-00 Route 208, Suite 2-5,
Fair Lawn, NJ, 07410

Consent for Services and Treatment

I understand that my child is presenting in the office today for dental treatment. Treatment includes all services that Dr. Hernandez or Dr. Soyupak may deem necessary to the patient's health including diagnostic services such as exams and/or x-rays, and minimally invasive services such as SDF (Silver Diamine Fluoride), placement of resin modified glass ionomer, SMART technique, and HALL Crown. As his / her parent/guardian I agree to all treatment that the doctor may deem necessary for the patient's health, prior to and/or during treatment to be performed. I also acknowledge that treatment may be amended from what was previously planned due to changes that are found on the day of treatment, prior to or during treatment. **Please Initial here:** ______

In the case that the patient does not cooperate and treatment cannot be performed, patient/guardian agrees to pay the charge of **$120** for the time, effort and/or nitrous gas performed by the doctor. **Please initial here:** ______

Upon signing this document, the patient/guardian agrees to fully understanding and accepting the terms of agreement below:

- I understand that the full cost for treatment or copay based on private insurance coverage is expected on the day of service. **Please initial here:______**
- I also understand that although the copay may be collected, it is only an estimate. **Please initial here:______**
- If the full amount is not collected by the patient's insurance, patient/guardian is responsible for payment of the full balance. **Please initial here:______**
- Payment can be made with cash, or a credit card charge. **Please Initial here:** ______

Should it become necessary for Bergen Pediatric Dentistry to pursue legal action or to use an outside agency to collect payment, I understand that I will be additionally responsible for any and all charges that Bergen Pediatric Dentistry incurs as a result of this action.

Parents of Minor Patients: The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Bergen Pediatric Dentistry will not be involved with separation or divorce disputes. **Please Initial here:** ______

Thank you for taking the time to review Bergen Pediatric Dentistry's policies. Please feel free to ask any questions or share with us special concerns.

By willingly signing below, I am agreeing that I have read and understand the above statements and I agree to the terms.

Patient's Name: ____ DOB: ____/____/____

Guarantor Print and Sign Name: _____________________________________Date: ____/____/____