Charles E. Hagan, D.D.S., M.H.S.
Juan C. Rodriguez, D.D.S., M.S.

Periodontics with Services in Dental Implants
Diplomates, American Board of Periodontology

AUTHORIZATION FOR RENDERING OF SERVICES

I, the undersigned (patient or legally responsible party) authorize permission to the staff of Charles E. Hagan, D.D.S., M.H.S., P.C. to render treatment. I hereby acknowledge financial responsibility relative to the charging of professional fees to my account. All fees are interest free for 60 days from the date of service. After a period of 60 days, a finance charge will be assessed at a rate of 1 1/2% per month on the unpaid balance.

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Signature of Patient or Guardian　　　　　　　　　　Date

AUTHORIZATION FOR INSURANCE RELEASE

I authorize the release of any information regarding the history, treatment or benefits payable to my insurance company for the purpose of validating and determining benefits payable in connection with claims. I authorize payment of insurance benefits directly to Charles E. Hagan, D.D.S., M.H.S., P.C. unless otherwise payable to me (these payments are to be forwarded to this office upon receipt). It is my understanding that as a courtesy, the office staff of Charles E. Hagan, D.D.S., M.H.S., P.C. will assist me in the filing of pre-authorizations and insurance claims for treatment. I understand, however, that all charges are my responsibility from the date of services rendered, regardless of my insurance coverage.

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Signature of Patient or Guardian　　　　　　　　　　Date

CANCELLATION POLICY

We require 24 hour advance notice if an appointment must be changed. Without advance notice, a missed or canceled appointment may result in a $25.00 charge to you.