Media Najafi D.D.S.
Cosmetic, Family, & Implant Dentistry

Agreement and Consent

Initial and sign

_____I authorize Dr. Najafi or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.

_____Upon such diagnosis, I give authorization to perform all recommended treatment mutually agreed upon.

_____I understand that payment is due at time of service.

_____I understand and agree to be responsible for payment of all services rendered on my or dependents behalf.

_____I understand that my dental insurance does not pay for the full treatment fee and that I am responsible for all payments not covered by my insurance, including the yearly deductible and co-payment fees determined by my insurance.

_____I understand that a 1.5% monthly finance charge (18.0% APR) plus the cost of any necessary collection fees.

_____I understand that failure to keep an appointment results in expenses to this office and agree that if I cancel an appointment with less than 24 hours notice or fail to show. I will be charged a fee (at the doctor's discretion) of no less than $50.00 for a late cancellation and $75.00 for failure to show for appointment.

_____**Saturday, Sunday, or after hours emergency visits are $225.00 which includes exam, x-rays and if needed prescriptions.** If you have dental insurance, we cannot check eligibility at the after hours times and payment is due on day of service. Your insurance will be billed and we'll have them send payment directly to you.

Patients Signature_____ Date_____

Parent/Responsible Party's Signature_____ Date_____