Brown Mobile Dental
PO Box 122295
Fort Worth, Texas 76121
817-335-5555

Responsible Party Private Pay Agreement

Consent to Examination & Payment Agreement

Proposed Services:

Please indicate with a check mark the services you are authorizing; note that an exam is required before a cleaning or x-ray can occur.

1.	Complete oral examination and cancer screening	$ 99.00
2.	Therapeutic Scaling Type II for treatment of gum disease	$199.00
3.	Complete Diagnostic X-rays (necessary for a treatment plan)	$159.00

I/We give consent for dental services noted above for:

I/We agree to pay $99 for the exam, $199 for the cleaning, and $159 for the diagnostic x-rays (if they are needed). I/We authorize the release of x-rays and photographs for demonstrative purposes, and hereby authorize the nursing facility to release the clinical records to Brown Mobile Dental. As the Responsible Party/Parties, I/We have read the above and agree to fulfill the payment requirements therein.

Note that payment for the procedures chosen above is required before they can be scheduled. We accept most forms of payment, including check, cash, or credit card. Credit card payment can be taken over the phone or processed with the information provided below. If we are unable to provide dental services because the patient is uncooperative, the money will be refunded minus a $70 trip fee.

_____ _____
Patient Name (Print) Date

_____ _____
Financial Responsible Party Signature Date

Credit Card Payment

Circle: Mastercard Visa Discover American Express #_____

Expiration Date ____/_____

Security Code _____ [3 digit code on the back of MC/Visa/Discover, 4 digit code on front of Amex]

Billing Address: _____ City _____ State _____ Zip _____

Receipt Preference: Mail Email Email Address: _____