Marzie Zahedi D.D.S.

INSURANCE ASSIGNMENT AND RELEASE

I, hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Marzie Zahedi, I also authorize the release of any information pertaining to my child's dental claims. **The patient/parent is responsible for any co-payments, deductibles, non-covered services and any portion that is over benefit year maximums.**

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment unless other arrangements are made. I agree that the parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

MINOR/ CHILD CONSENT

I being the parent or guardian of _____ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, prophy, and fluoride treatment, which are deemed advisable by the doctor, whether or not I am present at the actual appointment.

APPOINTMENT POLICY

1. 24 hour notice is required for the cancellation of dental appointments. Less than 24 hour notice is considered a missed appointment.
2. Periodic examination and cleaning is recommended every 6 months for our active patients. Failure to do so, will result in having your child become inactive. This may be a consideration for withdrawal from our services.

I HAVE READ AND AGREE TO THE ABOVE STATEMENTS

_____ _____

SIGNATURE PARENT/GUARDIAN DATE