TIBA DENTAL, P.C.
ABDELHAMED TAMARA D.D.S

C O N S E N T T O T R E A T M E N T & F I N A N C I A L R E S P O N S I B I L I T Y

Patient Name: ______________________________

Patient DOB: _______________________________

Patient SS# ________________________________

FINANCIAL RESPONSIBILITY: By accepting any medical service or treatment, including but not limited to consultations, examinations, x-ray or any dental work, the undersigned patient/responsible party agrees pay TIB DENTAL, PC. for such service or treatment.

IF CHAMPUS, MEDICARE, MEDICAID, WORKER'S COMPENSATION, or a similar government program should determine that I am not eligible for coverage or that the service or treatment is not covered, I will be responsible for payment, unless prohibited by law.
If I have health insurance, I assign the insurance benefits to pay, and authorize and direct my insurance carrier to pay those benefits directly to TIB DENTAL, PC. I will be responsible for payment of amounts not paid by my insurance.

____

(signature of patient) (date of signing) (time of signing)

____

(signature of patient's agent or representative/relationship) (signature of insured)

466 -78th Street
Brooklyn, NY 11209

Tel: (718) 491- 6585
Fax: (718) 491- 6586