ACKNOWLEDGMENT & CONSENT:

The information provided by me to Klekamp Family Dentistry is true to the best of my knowledge. I have read and understand the insurance, financial and office policies and acknowledge that I am responsible to pay for services rendered, including interest at 18% per annum on any balance more than 90 days past due. I understand that if my account is turned over for collections that I am responsible for reasonable attorney's fees, collection fees in the amount of 25% of the principal balance due. I further understand that any check returned by the bank will be assessed a $25 fee.

I hereby authorize David H. Klekamp, DDS, P.C. to furnish or obtain any/all information to/from insurance carriers, the referring doctor or PCP, physicians, other agencies to whom we refer, or designated next of kin or caregiver concerning treatments. I authorize the release of information necessary to process my claim. I hereby authorize payment to the dentist named, of the benefits otherwise payable to me.

Patient Name (if different from the responsible party):

_____

Name (Print)

_____ _____

Signature (Patient, Parent, Guardian) Date