



# Ashburn Children's Dentistry Consent to Treat Alternate Adult Representation

\*Parent consenting to alternate adult representation must be one of the parents listed on original paperwork for the patient. If you have a question about who is listed on your child's original paperwork, please call our office for details. 703.723.8440

Date \_\_\_\_\_

I, \_\_\_\_\_, the parent of \_\_\_\_\_,  
Parent Name (printed) Patient Name(s) (printed)

request Ashburn Children's Dentistry to accept consent to treat by \_\_\_\_\_

in my absence. They may consent to treatment for any routine 6 month appointments (professional cleaning, fluoride treatment, any necessary x-rays), restorative treatment (fillings, extractions, sealants, etc), soft tissue surgery (frenectomy, gingival recontouring, etc.) as treatment planned by a pediatric dentist of Ashburn Children's Dentistry. I understand that the person visiting Ashburn Children's Dentistry will be required to submit payment for services rendered (or a portion thereof if in-network or PPO insurance plan is on file). I understand that I may choose to keep a credit card number on file for this circumstance and it will be charged on dates of service where I am not present when the above named person is attending dental appointments with my child(ren). If I do not have a credit card on file, I understand that the above named person will be responsible for any payment necessary as Ashburn Children's Dentistry will not bill me for services performed.

\_\_\_\_\_  
 Parent Name (Signature)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Alternate Responsible Party (Signature)

\_\_\_\_\_  
 Date



# Ashburn Children's Dentistry

44025 Pipeline Plaza

Ashburn, VA 20147

703.723.8440

703.723.8443 fax

## PAYMENT AGREEMENT FOR SERVICES RENDERED AUTO-BILL TO CREDIT CARD ON FILE

Patient Name: \_\_\_\_\_

Responsible Party Name: \_\_\_\_\_

SSN: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Charge Date: 30<sup>th</sup> of Each Month

Credit Card Type: (circle one)

Visa

MasterCard

Amex

Card Number:

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration Date: \_\_\_\_\_ / \_\_\_\_\_

**Please utilize this payment agreement for**

- All balances remaining on a monthly basis
- All balances due on visits where I am not present and an alternate responsible party came with my child.

**Charge up to \$\_\_unlimited\_\_ of balance/mo./transaction**

**Any balance exceeding \$\_\_n/a\_\_\_\_\_, please call responsible party to inform of balance and to authorize transaction.**

**Please x Send  Do Not Send Receipt with each transaction.**

**Balances will be automatically charged to the credit card on file on the 30<sup>th</sup> of the starting month of the payment agreement. If payments are paid by their set due date, no finance charges or late fees will be assessed. A \$10 service fee will be assessed for each month a payment cannot be processed due to an incorrect or cancelled credit card number is on file.**

Signature: \_\_\_\_\_ Date \_\_\_\_\_