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: 30th 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 30th 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_____