



**PLEASE READ AND INITIAL:**

\_\_\_\_\_ I understand and agree I have the ultimate financial responsibility for services rendered. I am financially liable for all services, all non-covered charges as well as for all co-pays and/or all deductibles under private insurance. I also understand that it is my responsibility to update all insurance information by providing timely updated information.

\_\_\_\_\_ I understand and agree that should I and/or my dependents miss two appointments without a 24 hour notification (no-show), I or my dependents may be considered inactive or possibly released by T. G. Braswell, D.D.S., P.C. I will be charged a \$25.00 broken appointment fee.

\_\_\_\_\_ I have received a copy of T. G. Braswell, D.D.S., P.C. Notice of Privacy Practice.

\_\_\_\_\_ I authorize T. G. Braswell, D.D.S., P.C. and its staff to perform dental evaluations and provide treatment as deemed necessary.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Responsible Party