



# TriState Family Dental Centers

A Professional Corporation

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*Established in 1971 by  
John B. Schymik, D.D.S. & Stanley R. Nevill, D.D.S.*

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## Third Party/Parental Liability Form - Patient Over Age 18

Patient's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Today's Date: \_\_\_\_\_

\_\_\_\_\_ I intend to continue financial obligation for the patient listed above.

Select one:

- \_\_\_\_\_ This consent is ongoing, and shall remain in effect until revoked in writing by the undersigned.
- \_\_\_\_\_ This consent shall remain in effect until the patient above reaches the age of \_\_\_\_\_.
- \_\_\_\_\_ This consent is for treatment on: \_\_\_\_\_ (Date)

Please fill out the contact information below for any further correspondence:

Name: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_

### FINANCIAL RESPONSIBILITY AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize my signature on all insurance claim forms at the offices of TriState Family Dental Centers for payment directly to them for services rendered. I authorize TriState Family Dental Centers to make and send copies of dental records that may be needed to file my insurance claims. I understand that I am responsible for charges incurred regardless of whether or not my insurance pays. I understand that office policy requires payment in full or the estimated portion not covered by insurance at the time of service unless other arrangements have been made with the credit manager. Past due balances are subject to a 1.5% per month (18% APR) service charge. I understand and agree that if any unpaid balance is assigned to a third party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of 33.33% will be added to my account. I further agree to pay reasonable attorney fees and court costs. I understand and agree to the above terms.

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

**Please mark an X on the line indicated and sign below if you do not intend to continue financial responsibility.**

\_\_\_\_\_ I will not continue financial responsibility for the above named patient. Please remove him/her from my account.

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