Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for **Srdjan Ilic-Siljak, D.M.D.**, to furnish dental care and treatment to ________________________________considered necessary and proper in diagnosing or treating his/her physical condition.

Authorization and Release

I, hereby assign all medical benefits to include Medicare, private insurance and third party payors to, **Srdjan Ilic-Siljak D.M.D.,** otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. If, however, **Srdjan Ilic-Siljak D.M.D**. is not a provider for my insurance carrier, I understand and agree that I shall be treated on a Fee-For –Service basis. I agree, acknowledge and understand that I am responsible for payment of all services rendered on my behalf or my dependent(s). In case of default on payment, I agree to pay any cost of collections or attempt to collect, court cost and reasonable attorney fees incurred in attempting to collect on this amount. The term "cost" shall include, but is not limited to, court costs, reports, witnesses, statements, long distance telephone charges, and all other expenses, if any, directly incurred in investigating, handling or litigating this collection. Interest shall accumulate on any unpaid balance at the rate of 1.5% per month. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including medical Records, to secure payment.

All health records held in ownership by **Srdjan Ilic-Siljak D.M.D**. will be considered confidential. All employees of **Srdjan Ilic-Siljak D.M.D**., are responsible for making sure that no unauthorized person ever takes these records out of the files, reads, copies, or otherwise tampers with them in any way or at any time, whether it is before, during or after the patient's stay.

I UNDERSTAND AND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

________________________________ ____________________

Patient or Guardian Signature Date