EAST FALLS FAMILY DENTISTRY, LLC

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Welcome to the East Falls Family Dentistry, LLC. Dr. Hyosun Christine Kim D.M.D. and staff welcome you! We would like to inform you that we do not provide silver/mercury contained fillings due to unproven safety of the materials. Please read the attached information sheet about amalgam/silver filling. We are mercury free dental office and some insurances, unfortunately, do not have coverage for white fillings (resin/composite). Our staff is well trained and is working hard to find out your ESTIMATE of co-pays for white fillings for your convenience. It is, however, your responsibility that you are responsible for your account. I read information sheet of dental amalgam and approve that white filling will be placed instead of silver/amalgam filling(s).

I am responsible for the remaining balances of any service rendered whether or not paid by insurance. East Falls Family dentistry, LLC will not deliver the final product of crown, bridge, implant, invisalign trays, denture, night guard and/or any lab processed product until payment is made in full or payment plan is made prior.

X X

Signature and print your name DATE

I refuse to get white fillings and/or treatment plans.

Signature and print your name DATE

**-OVER-**

Certification

To the best of my knowledge, the information provided on this form is complete and correct. I
understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/CHILD consent.

I am the parent, guardian, or personal representative of\_X (please print name of minor/child) and there are no court orders not in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present wh1~n the treatment is rendered.

INSURANCE ASSIGNMENT AND RELEASE

I certify that my dependent(s)/myself is covered by insurance with X (name of insurance company)and assign directly to Dr. Kim, EAST FALLS FAMILY DENTISTRY, LLC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance; I authorize the use of my signature on all insurance submissions.

Dr. Kim may use my minor/ child's health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is complete or one year from the date signed below.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardian or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibilities for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

X X Signature of patient, parent, guardian or personal representative Date

X X

Please print name of parent, guardian or personal representative Relationship to patient