ACKNOWLEDGMENT OF DISCLOSURE AND ACCEPTANCE OF
MEMBER FINANCIAL RESPONSIBILITY

CONSENT FORM

_____

Name of Member (the "Member") – *please print clearly*

_____

Treating Provider (the "Provider") – *please print clearly*

_____

Office/Location Name and Address

The Member or the Member's legal representative hereby acknowledges that he or she has been informed that the following health care services to be provided to the Member have not been approved for payment under the Member's health benefit program.

Accordingly, the undersigned agrees that the Member or Member's legal representative, and not the applicable health benefit program, will bear full financial responsibility for payment of all charges for these services.

Code	**DOS** (if applicable)	**Tooth/Surface/Arch**	**Cost**

Date: _____

Signature of Member or Member's Legal

Representative

Witness: