Seth Roth D.M.D.
450 Pearl Street
Stoughton, MA 02072
781-344-5543

**Parental Financial Responsibility Form**

I, _____ accept financial responsibility for all dental treatment provided by Dr. Seth Roth for my child_____. I acknowledge my child is age 18 or over and I still choose to be financially responsible until they reach the age of _____.

Initial _____ Date_____

I have been provided a copy of Dr. Roth's Office Policy and when applicable their Insurance Coverage Policy. I have read and understand the above named policies and agree to their terms.

Initial _____ Date_____

I acknowledge my child must sign a HIPPA release form giving consent to Dr. Roth and his staff to discuss his/her dental information, financial information and services that have or may be provided to obtain optimal dental health.

Initial _____ Date_____

I understand I can terminate this agreement within 30 days of the office receiving written notice of my intent to terminate. I am aware that any treatment started prior to providing the office with the aforementioned termination notice will be my financial responsibility.

Initial _____ Date_____

Parent's Signature _____

Date _____