PREMIERE DENTAL

Refund Release Form

Treatment Cost: _____
Lab Cost: _____
Refund amount: _____

The patient, _____, will hold harmless and indemnify Doctor _____ against any claims, and actions in exchange for $_____. The patient, _____, hereby releases Doctor_____, and all other involved persons and their successors from all claims and liabilities arising from treatment provided by the doctor during my time as a patient at Premiere Dental. I make this decision of my own free will relying upon my knowledge and judgment of any injury I may have sustained during treatment and my decision to release has not been affected by any false statements or representations pertaining to those injuries. I understand that this action is just a business decision and agree this represents a compromise regarding a dispute between the patient and the doctor. Accordingly, this payment or waiver of the fee is not an admission of any liability regarding the doctor. Further, the terms and conditions of this settlement are to be kept confidential and will not be disclosed to any other party in the future. I have carefully read this release and understand its contents, and I am signing it of my own free act.

Patient Name: _____ Signature: _____ Date: _____

Doctor Name: _____ Signature: _____ Date: _____