Lakeline Ranch Dental

**Consent for Elective Cosmetic Treatment**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name Date

I hereby authorize Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and designated assistant(s) to perform the following

ELECTIVE treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand this is ELECTIVE COSMETIC TREATMENT, NOT NECESSARY TO TREAT DENTAL DISEASE AND THEREFORE NOT SUBMITED TO INSURANCE. I ALSO UNDERSTAND THIS FEE IS FOR COSMETIC TREATMENT AND NOT AN INSURANCE DISCOUNTED PROCEDURE.

Financial Policy:

Signing this document does not obligate me to start treatment, it simply ACKNOWLEDGES THAT:

* My dental condition and treatment options have been fully explained to me and my questions have been answered.
* Treatment fees are valid for 6 months for the date shown above and are subject to revision.
* Treatment and fees may be different than the above plan if my dental needs change, which may not be evident until treatment is started.
* Payment in full is due at time of service.

I have read and understand the above statements.

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Patient’s or Guardian’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness’ Signature Date