CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of________________________’s dental needs.
(Please print patient’s name)

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor’s or designated staff’s use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% monthly late charge (18%APR) may be added to my account. If required, I also understand that a check of my credit history may be made.

5. I understand that when I schedule an appointment, the doctor is reserving that time for my treatment. Since it is not the policy of this practice to double book patients, 48 hour notice is required to reschedule or cancel any appointment or I will be charged a $50 per hour fee.

Patient’s Signature: ______________________ Date: __________ Witness: _____________________

Patient/Responsible Party’s Signature: ___________________ Relationship to Patient: _____________