CONSENT FOR TREATMENT

Patient : last name : _____ first name : _____ mid name : _____

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 (name of patient) _____ 's dental needs.
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 identi able 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.
5. In the event payment is not received within thirty (30) days of its due date, then I agree to pay 1 1/2% per month service charge (18% APR) on the overdue balance until paid. In the event that my account is referred to an attorney for collection, then I agree to pay attorney's fees in the amount of 33 1/3% of the overdue balance and I further agree to pay all court costs incurred in the collection of the over due balance.

Patient's Signature: _____ Date: DD / MM / YYYY Witness: _____

Guardian's Signature: _____ Relationship to the Patient : _____