CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed necessary by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon 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 may ask for a complete recital of all possible complications.

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

5. I agree to be responsible for payment for any and all services rendered on my behalf or on my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I understand that dental insurance benefits may pay only a portion of the fees and I will be financial responsible for any portion of the fees not covered by the insurance benefits. In the event payments are not received as agreed upon, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

6. Cell Phone: I consent to the dental practice to contact me by using me cell phone number to (choose one or both options) call___ and/or text ____ regarding appointments, regarding treatment, insurance and my account.
My cell phone number is (_____) _____-_____.

7. I consent to the dental practice to contact me by email regarding appointments, regarding treatment, insurance and my account.
My email address is _____.

Patient_____

Date_____ Witness_____

Parent or Responsible Party _____

Relationship to Patient_____