Consent for Treatment

1. I hereby authorize the doctor or designated staff to take **x-rays, study models, photographs and other diagnostic aids** deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by us.

2. I agree to the use of anesthetics, sedatives and other medications 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.

3. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other prior arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account.

4. I understand my confidential treatment record and financial information has been fully protected under the Privacy Rules governed by the Health Insurance Portability and Accountability Act (HIPAA). My personal health information will be shared exclusively for treatment, payment and/or healthcare operations with specialists or insurance carriers only, at my request and approval.

Signature: _____Date:_____

In order to offer you more choices in scheduling, may we call you if we have time that becomes available prior to any already scheduled appointments?

Yes_____ No_____