

INFORMED CONSENT FOR TREATMENT

The undersigned hereby authorizes the Doctor or designated staff to take necessary x-rays, study models, photographs, or use any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. The Doctor is authorized to perform any and all forms of treatment, medication, and therapy that may be indicated and agreed upon in connection with (name of patient)

_____. Consent and authorization is given for the Doctor to choose and employ such assistance as deemed appropriate. It is understood that the use of anesthetic agents embodies a certain risk, including temporary or permanent residual paresthesia, in rare instances.

PAYMENT FOR DENTAL SERVICES provided in this office for me and/or my dependants are due and payable at the time services are rendered. The undersigned authorizes the release of any information necessary in connection with the processing of dental insurance claims. Insurance claims may be generated on behalf of the patient as a courtesy, ONLY if all necessary information is provided. Any insurance compensation will be issued directly to the Doctor. The undersigned also promises to pay legal interest in the event indebtedness is incurred, together with such collection costs, court costs, and reasonable attorney fees as may be required to effect collection of note.

APPOINTMENTS ARE FIRM RESERVATIONS and *punctuality is requested*. In the event of an *emergency, as much notice as possible is required*. Should it become necessary, appointments may need to be reserved with a credit card, in which the undersigned agrees to pay charges of **up to \$150.00** if agreed upon appointment is not kept.

Patient OR Responsible Party

Relationship to Patient _____ Date
