

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 and/or medical needs.
(Name of Patient)
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 my 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 caring 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. 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 services unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 ½ % late charges (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.
6. I give my permission for my or my dependents diagnostic and treatment records to be used for purposes of research, education, or publication in professional journals.

Patient's or Guardian's Signature

/ *Relationship to Patient*

Today's Date