CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, videos, photographs, and any 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 authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents at the time of service unless other arrangements have been made. I understand that a 1-1/2% late charge (18%APR) will be added to my account.

5. I agree to give at least 48 hours notice and/or two working days for any cancellation of an appointment time. A minimum fee of $50.00 but, not to exceed the actual fee for scheduled treatment will be charged if an appointment is failed without proper notice.

6. By signing below I certify that I have read and understand the above information to the best of my knowledge.

Patient_____Date_____

Parent/Guardian_____Date_____

Relationship to patient:_____Staff Initials_____