
# *CONSENT FOR TREATMENT AND PAYMENT*

**We Welcome you to our practice and look forward to helping you achieve the healthy beautiful smile you deserve.**

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 (name of patient) _____,s dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon as required to provide proper care.
2. I agree to the use of anesthetics, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete explanation of any potential complications.

**PLEASE READ AND INITIAL**

3. 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 service unless other written arrangements have been made. Your treatment will be based on what you feel are your chief concerns as well as our exam finding. *If insurance is utilized then the co-payment for each procedure is due at the time of services rendered. Since insurance providers regularly change benefits, deductibles, and plan years, we cannot accurately predict what will be covered in your plan. Your dental health is the first concern regardless of your insurance coverage. I understand that it is my responsibility to contact my insurance company should a claim be denied or not paid in full. I understand that I am responsible for all charges, whether or not they are covered by my plan*
   (Initials please)_____
4. We see all patients on an appointment basis, doing our best to see all patients on times. We request that you arrive promptly for the time we have reserved for you. If for any reason you need to make changes to your scheduled appointment, we require a 48 HOUR notification CALL during business hours, so this time may be offered to another patient. We understand that unforeseen circumstances arise, but in the event that we do not receive 48 hours notice prior to a scheduled appointment or an appointment is missed for any reason without notifying our office, we reserve the right to charge a fee of $40.00
   (Initials please) _____

Patient/Responsible Party: _____ Date: _____

**Signature**

Relationship to Patient: _____ Date: _____