

## TREATMENT CONSENT

1. I, (name of patient) \_\_\_\_\_ 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 for my dental needs.
2. Upon completion of 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 medications as necessary. I fully understand that using anesthetic agents may contain certain risks. I understand that I can ask for complete information of any possible complications.
4. Per HIPAA regulations my consent is given to the doctor or designated staff's for the use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying 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 fully accept responsibility 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 arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_ .

Parent/Responsible Party's Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ .