

Consent

- ❖ I, the undersigned, hereby authorize the Doctor to take x-rays, photographs, study models or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs.
- ❖ I authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated.
- ❖ I understand the use of anesthetic agents embodies a certain risk.
- ❖ I understand that my dental insurance is a contract between me and the insurance carrier and not between the insurance carrier and the Doctor and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made.
- ❖ I assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred.
- ❖ I understand that a late charge will be added to any overdue balance.
- ❖ I understand that where appropriate, credit reports may be obtained to determine my eligibility for financing options.
- ❖ I have received the Payment Policy, Broken Appointment/Cancellation Policy and HIPPA (Privacy Practices) Notice.

Signature: _____

Date: _____