

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 the doctor to make a thorough diagnosis of dental needs.
2. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a completed recital of any possible complications.
3. I give 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 carrying out my treatment, payment and health care operations. I understand that only the minimum amount 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.
4. 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. In the event payment is not received by the agreed upon date, I understand that a 1-1\2% late charge (18% APR) may be added to my account. If services are not paid for by the patient, Restoration Dental, P. C., may use methods to collect monies, including the following, but not limited too: collections agencies, collection calls, and representation by a law firm with any fees being incurred by the patient.
5. The diagnosis, proposed therapy, and any other reasonable treatment alternatives have been explained to me, as well as the prognosis with and without the proposed therapies. The risk associated with treatment, including failures with some cases despite treatment, has also been explained. The costs may vary according to treatment.
6. I understand that this consent form covers any and all procedures carried out in this office from this day forward.

Name (printed) _____ Signature _____

Parent or Guardian if minor _____ Date _____