

## **Consent for Treatment**

I understand the preceding medical history information is necessary to provide me with dental treatment in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my health history or medication.

I hereby authorize the doctors, 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 my dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by the doctor, and to employ such assistance as required to provide proper care.

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.

Photo consent: If any before/after photos are taken of dental work performed, I give the doctor permission to use photos for educational purposes and lecture presentations.

### **Financial Policy**

1. **If you have dental insurance** that is currently of effect, we may begin treatment against anticipated insurance benefits.

Remember, insurance is a contract between you and your insurance carrier. Some insurance companies pay more and some pay less. **We will estimate your portion of payment, which will be due at the time of treatment. Any balance that is outstanding after 60 days is entirely your responsibility.**

2. **If you do not have dental insurance**, payment is due for services as they are rendered.

We accept all major credit cards as well as checks and cash. We do NOT extend credit. Instead, we suggest private financing. We also have financing available through Care Credit and ChaseHealthAdvance. Our financial Coordinator would be happy to give you more information on this option.

I understand the consent for treatment and the financial policy of this office regarding "If you have dental insurance"/ "If you do not have dental insurance." I further agree to pay all finance charges, collection cost, attorneys fees and any other cost that may be incurred to enforce collection of any amount outstanding. A late fee of \$25 will be added after a balance is past 90 days due. I agree to the terms of this financial policy. I will pay by:

Check \_\_\_\_\_ Cash \_\_\_\_\_ Credit Card \_\_\_\_\_ Other \_\_\_\_\_  
(\$25 charge for returned checks)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date