



Financial Responsibility

I understand that I am responsible for any and all charges incurred at the time of service. As a courtesy to you, we will file your insurance and they will directly reimburse you.

Signed _____

Date _____

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of:

(Name of Patient) _____'s dental needs.

2. Upon such 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 medication as necessary, fully understand that using anesthetic agents embodies certain risk. I understand that I can ask for a complete recital of any possible complications.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service.

Signed _____

Date _____

PLEASE COMPLETE REVERSE SIDE

**Acknowledgement of Receipt
Of Notice of Privacy Practices**

Print Name _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature

Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- Unable to communicate with the patient for the following reason:

Other: _____

Prepared By _____

Signature _____

Date _____

PLEASE COMPLETE REVERSE SIDE