GENTLE CARING DENTISTRY
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 doctor to make a thorough diagnosis of ___________________________'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me to employ such assistance as required to provide proper care.
3. 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.
4. 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 options. 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 protections of my personal health information is available.
5. I HAVE READ, UNDERSTAND, AND ACCEPT THE TERMS OF THE ABOVE OUTLINED POLICIES FOR INSURANCE HANDLING AND FINANCIAL COMMITMENTS THAT I MAY INCUR AS A RESULT OF TREATMENT. I KNOW THAT ANYTHING INSURANCE DOES NOT COVER IS MY RESPONSIBILITY. IF NO INSURANCE, I KNOW THAT ALL PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. I KNOW THAT IF I DON'T PAY MY OUTSTANDING BALANCE, AND THE ACCOUNT IS SENT TO COLLECTION OR SMALL CLAIMS COURT, I WILL BE RESPONSIBLE FOR ANY LATE CHARGE (18% PER ANNUM INTEREST RATE), ATTORNEY FEES OR COLLECTION FEES THAT MAY BE INCURRED.

Patients Signature ____Date _____________

Parent/Responsible Party's Signature ____Date_____________

Relationship to Patient ____