PREMIERE DENTAL

Consent For Treatment

- I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnosis aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) dental needs.

- Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such as assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives, and other medication as necessary. J fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complication.

- Premises are under 24-hour audio and video surveillance.

- I give consent to the doctors or designated staffs 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 of 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.

- I agree to be responsible for payment of all services rendered on my behalf or my dependent. I understand that payment is due at the time of service unless other arrangements have been made.
- If for any reason my account is sent to collections, a 50% collection fee will be added to my balance and turned over to a collection agency.

Patients Signature: _____ Witness: _____

Parent/Responsible Party's Signature: _____
Relationship to Patient _____