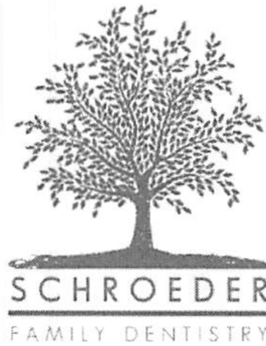

CONSENT FOR TREATMENT

1. I hereby authorize the doctors at Schroeder Family Dentistry or their designated staff members to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of (name of patient) ______________________'s dental needs.
2. Upon such diagnosis, I authorize the doctors to perform all recommended treatment, mutually agreed upon by me, and to employ such assistance as required to provide for proper care.
3. I agree to the use of anesthetic, sedatives, and other medications and receiving dental care 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 to use and disclose 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 health information is available.
5. I agree to be responsible for payments of all services rendered on my behalf or on behalf of my dependents. I understand that payment is due at time of service unless other arrangements have been made. In the even that payments are not received by agreed upon dates, I understand that a late charge of 1.5% times the unpaid balance per month (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature: ____________________________________ Date: ________________

Parent/legal guardian's signature: ________________________ Relationship: ___________

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