CONSENT FOR SERVICES FOR PATIENT

Last_____First_____M.I._____Preferred name_____

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me 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 complication.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service. I also understand that any returned checks or insufficient payments will be assessed a $25 fee and the entire balance will be required to be paid immediately. I agree that in the event my account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, cost, expense and court cost incurred in the collection.

As a condition of treatment by this office, financial arrangements must be determined before treatment. As a courtesy to our insurance patients, we file your dental insurance. We will always do our best to help you maximize your dental benefits, however ultimate responsibility for payment is yours and financial arrangements must be defined prior to beginning dental treatment.

I understand if I cancel an appointment with less than 24 hour notice, there may be a failed appointment fee which I agree to pay before any further appointments can be made.

I acknowledge that I have reviewed the Broad Street Smiles Notice of Privacy Practices on www.broadstsmiles.com and can get a copy upon request.

I acknowledge that I have reviewed the Dental Board of California's Dental Materials Fact Sheet on www.broadstsmiles.com and can get a copy upon request.

I grant my permission to you or your assignee to telephone me to discuss this statement, my account, appointments or my treatment.

I consent to the making of photographs and x-rays before, during and after treatment, to be used by the doctor in scientific papers or demonstrations.

- ☐ ***I understand that the new patient cleaning (included with the new patient special)must be completed within six months of the initial exam date.***
- ☐ *I have read the above conditions of treatment and payment and agree to their content.*

Signature of patient, parent or guardian (responsible party):

_____ _____

Signature-Patient/Guardian *Date*