ORCHARD DENTAL GROUP™
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Number 12
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CONSENT FOR TREATMENT

Consent for Treatment

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 _____(name of patient)'s dental needs. 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.

I hereby authorize the doctor or designated staff to use above diagnostic aids to consult with doctors, laboratories, or dental study groups and for patient education.

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.

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

_____ Date_____

Signature of patient or parent/guardian (if minor)

Authorization and Signature Request

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 unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account, and that I am responsible for any and all collection costs, including, but not limited to court costs and attorney fees. If required, I also understand a check of my credit history may be made. In the event payments are not received by agreed upon dates, I understand that an Orchard Dental Group representative may call to collect any unpaid balance.

I understand that insurance is considered a method of reimbursing the *patient* for fees paid to the doctor and is not a substitute payment. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize and request my insurance company to pay directly to the dentist the dental group insurance benefits otherwise payable to me.

_____ Date_____

Signature of patient or parent/guardian (if minor)