

Palmer Dental Associates, P.C.

Kamal Haddad, D.D.S.
2710 William Penn Highway
Easton, PA 18045
610-253-4343

Consent for Treatment

I authorize Haddad Family Dentistry, P.C., to take X-rays, diagnostic casts, photographs, or any other diagnostic aid deemed appropriate by the dentist to make a thorough diagnosis of my dental needs and maintain my dental health. I also authorize arrangement for and/or administration of any sedative, analgesic, therapeutic, and/or other pharmaceutical agent(s) as prescribed by my dentist.

My signature below indicates that I understand the following:

The administration of local anesthetic may cause unexpected reactions or side effects, which may include, but are not limited to: bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness.

During and/or after completion of dental treatment, teeth, gums and/or surrounding tissues may be sensitive or painful, jaw muscles may be sore or tender, the tongue, cheek or other oral tissues may be abraded or lacerated (cut). Additional treatment may be required.

During dental treatment items including, but not limited to, teeth, crowns, small dental instruments, drill parts, may be aspirated (inhaled) or swallowed and may require further treatment.

Responsibility for payment for dental services provided in this office for myself or my dependents is mine, and due and payable at the time of services are rendered unless financial arrangements have been made. Dental insurance does not relieve me of financial responsibility for any unpaid balance.

A 1.5% finance charge per month (18% annually) will be added to any unpaid balance over 60 days delinquent. In the event of default, I the patient/guarantor promise to pay legal interest of the unpaid balance, together with collection costs and related reasonable attorney fees. There will be a \$35.00 charged for returned checks.

I speak, read or write English or the consent form has been sufficiently translated and explained to me.

The benefits, alternatives and risks of recommended treatment will be explained to me as appropriate and will have the opportunity to have my questions answered.

I understand that by signing this consent I have been informed of and given the right to review a copy of your Notice of Privacy Practices, of Haddad Family Dentistry, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA.

*******MISSED APPOINTMENTS WITHIN 24 HOURS NOTICE WILL RESULT IN A \$75 CANCELLATION FEE*******

Patient or Authorized Signature _____ Date _____

Kamal Haddad

Dentist Signature _____ Date _____

Witness Signature _____ Date _____

Patient's Name (Please Print) _____ DOB / /