Consent for Treatment

I authorize Haddad Family Dentistry, P.C., to take X-rays, diagnostic casts, photographs, or any other diagnostic deemed appropriate by the dentist to make a thorough diagnosis of my dental needs and maintain my dental health. I also authorize agreement for and/or administration of any sedative, analgesic, therapeutic, and/or any 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 dependent is mine, and due and payable at the time of services are rendered unless financial agreements 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 and a $5.00 billing fee. In the event of default, I the patient/guarantor promise to pay legal interest of the unpaid balance, together with collection costs and relative reasonable attorney fees. There will be a $35.00 charged for returned checks.

I speak, read or write English or the consent 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 HIPPA.

MISSED APPOINTMENTS WITHIN 48 HOURS NOTICE MAY RESULT IN A CANCELLATION FEE UP TO $75

Patient or Authorized Signature ______________________________ DATE ______________

Dentist Signature ______________________________ DATE ______________

Witness Signature ______________________________ DATE ______________

Patients Name (Please Print) ______________________________