Katherine King, DMD

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CONSENT FOR TREATMENT

1. I hereby authorize the doctor or a designated staff member to take study models, photographs and/or other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____.
2. Upon such 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.
3. I agree to the use of anesthetics, sedative, and other medications as deemed necessary. I fully understand that using anesthetic agents embodies certain risks.
4. I give consent to the doctor or designated staff to the use and disclosure of any oral, written, and electronic health records that are individual 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 personal health information is available.
5. I agree to 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 late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.
6. I agree to give a 24-hour notice if I need to cancel my appointment or I will be subject to a cancellation fee.

_____ _____ _____

Signature of Patient or Parent of Minor Date Witness