Rose City Dental Care
1234 SE 122nd Avenue
Portland, OR 97233
Tel. (503) 255-2415

PATIENT RESPONSIBILITY AND CONSENT AGREEMENT

Date _____

I hereby authorize and request the performance of dental services for myself and/or for:

_____

I also give my consent for any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes of dental treatment.

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.

The care of your teeth and gums is a partnership between you and your dental care provider. Neither of us would be successful without the work of the other. Our responsibility is to do the best work that is possible for you. Your responsibility is to come to your appointments, be on time, and make sure that your teeth and gums remain healthy after we complete your dental care.

VERY IMPORTANT! If you are unable to keep your appointment, please call the office with 24hours notice. This helps us to fill the time with someone who has been waiting for care. If you miss your appointment or cancel without 24 hour notice, you will be charged a $25 no show fee for each hour of your appointment. This charge may be greater if your insurance policy indicates. Also it is important to arrive on time. If you are more than ten minutes late, we will need to reschedule your appointment.

Children 17 years of age and under require the presence of a parent or legal guardian before any treatment is performed.

There will be a fee for duplication of x-rays.

I have read, understand, and agree to the provisions of the PATIENT RESPONSIBILITY AND CONSENT AGREEMENT.

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(Signature of patient/parent/guardian)