

Consent For Treatment

- * I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.
 - * 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 agree to the use of anesthetics, sedatives and other medications. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital and any possible complications.
- _____

Office Policy

Patients are seen daily by appointment Monday- Thursday 7:30 A.M. to 3:00 P.M. An appointment is especially reserved for you. We are conscious that your time is valuable also. We make every effort to provide prompt and efficient appointments. If you are unable to keep your reserved appointment we ask that you kindly give us 2 business days to avoid any possible broken appointment fees.

Payment Policy

We accept Cash, Check, MasterCard, Visa, Discover, and American Express. Longer term (up to 5 years) financial arrangements are available upon request. Payment or payment arrangements are expected at the time of service or prior to service in more extensive cases. As a courtesy we be happy to file your insurance then the reimbursement check will be mailed directly to you.

Patient's signature (or responsible party) _____

Date: _____