FINANCIAL POLICY

I have read and understand this financial policy.

I understand my insurance coverage is a contract between myself and my insurance company, and I agree to accept financial responsibility for payment of charges incurred.

Signature _____ Date _____

TREATMENT CONSENT

I hereby authorize and direct the dentist(s) assisted by other dentists and/or dental auxiliaries of his/her choice, to perform upon myself or my child (or legal ward for whom I am empowered to consent) the above mentioned dental treatment(s) or oral surgery procedure(s). I certify that I have read and understand this consent form, that I have been given an opportunity to ask questions and that all questions about the procedure(s) have been answered in a satisfactory manner. No guarantee has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. I understand further that I have the right to be provided with answers to questions that may arise during the course of my treatment or that of my child. I further understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I choose to terminate it.

Signature of Patient or
Parent/Guardian_____Date_____

Dentist Signature_____Date_____