

## Consent For Treatment and Financial Guidelines

I hereby authorize doctor or designated staff to make x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_ 's dental needs.

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 medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually 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.

I agree to be 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.

Signature \_\_\_\_\_ date \_\_\_\_\_

\_\_\_\_\_ initial. Under most instances, we can file your insurance (if applicable). Our goal is to have your insurance pay within 45 days of filing. After 45 days, the outstanding balance is the responsibility of the patient. Our office estimates your dental coverage and make no guarantees that they will pay exactly those amounts. Final responsibility for payment rests with the patient.

\_\_\_\_\_ initial. In order to see you in a timely matter, Dr. Goedecke has reserved a set amount of time for your appointment. Please give 48 hours notice when changing a dental appointment. Most cancellations within 24 hours will incur a \$50 fee.

Mastercard/Visa/American Express (please circle)

Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Signature: \_\_\_\_\_ date: \_\_\_\_\_