Authorization & Release

Consent

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor, mutually agreed upon by me, for the purpose of proper diagnosis.
2. The doctor teaches other dentists, therefore I authorize the use of any x-rays or photographs for educational purposes.
3. I authorize the doctor to perform recommended treatment, mutually agreed upon, and to employ such assistance as required to provide proper care.
4. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.
5. I agree to be responsible for payment of all services rendered on my behalf and that of my dependants. 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 the agreed upon dates, I understand that a finance charge (18% APR) will be added to my account.
6. In the event any attorneys are employed to enforce this contract obligation, any attorney's fees and costs, including the cost of experts, will be awarded to the prevailing party.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

What is your preferred method of payment? (Please check one) ☐ Visa/Master Card ☐ Cash ☐ Check

Authorization and release

I certify that I have read and understand the above information. I understand that providing incorrect information may pose a danger to my health. I authorize the dentist to release any information including the diagnosis and/or the records of treatment or examinations rendered to me or my dependent while under care to a third party payer and/or the health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Patient _____ _____

(Print name) (Signature of patient)

Date _____

MINT DENTAL