Consent for Treatment

I hereby authorize Rose Family Dentistry to administer any treatment, such as anesthetics, analgesics, sedatives, nitrous oxide sedation and to perform such dental operations or procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I will be informed of all possible complications of the procedures and/or anesthetics prior to treatment.

_____ Date: _____ Relationship to Patient_____
Signature of patient, parent or guardian

Consent for Services

Rose Family Dentistry would like to inform our patients that only composite (tooth colored) fillings are used in our treatment rather than amalgam (silver) filling. If you have any questions regarding this method of treatment Dr. Rose or Dr. Ruiz will be happy to explain. For our patients with insurance, please be aware that there may be a slight increase in your insurance co payment. As a condition of your treatment by this office, financial arrangements must be made in advance and credit information obtained when necessary. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office can not render services on the assumption that our charges will be paid by an insurance company.
A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
I understand that the fee estimate that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient's examination.
In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, with in the time for payment thereof. I further agree to pay all cost and reasonable attorney fees if suit be instituted hereunder.
I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content.

_____ *Date:* _____ *Relationship to Patient* _____
Signature of patient, parent or guardian

_____ *Date:* _____ *Relationship to Patient* _____
Signature of patient, parent or guardian