PATIENT'S NAME: ______________________________ DATE: ______________

TIME: ______________ (A.M.) (P.M.)

I HEREBY AUTHORIZE DR. ______________________________ AND HIS/HER ASSOCIATES AT ______________
______________________________ TO PERFORM UPON ME OR THE NAMED PATIENT THE FOLLOWING
PROCEDURE(S): ____
____ (EXPLAIN IN PLAIN ENGLISH).

DR. ______________________ HAS FULLY EXPLAINED TO ME THE PURPOSE OF THE PROCEDURE(S) AND HAS ALSO INFORMED ME OF EXPECTED BENEFITS AND COMPLICATIONS (FROM KNOWN AND UNKNOWN CAUSES), ATTENDANT DISCOMFORTS AND RISKS THAT MAY ARISE, AS WELL AS POSSIBLE ALTERNATIVES TO THE PROPOSED TREATMENT, INCLUDING NO TREATMENT. THE ATTENDANT RISKS OF NO TREATMENT HAVE ALSO BEEN DISCUSSED. I HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS, AND ALL MY QUESTIONS HAVE BEEN ANSWERED FULLY AND SATISFACTORILY. I ACKNOWLEDGE THAT NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME CONCERNING THE RESULTS INTENDED FROM THE PROCEDURE(S).

I UNDERSTAND THAT DURING THE COURSE OF THE PROCEDURE(S), UNFORESEEN CONDITIONS MAY ARISE WHICH NECESSITATE PROCEDURES DIFFERENT FROM THOSE CONTEMPLATED. I, THEREFORE, CONSENT TO THE PERFORMANCE OF ADDITIONAL PROCEDURE(S) WHICH THE ABOVE-NAMED DENTIST OR HIS/HER ASSOCIATES MAY CONSIDER NECESSARY.

I ALSO UNDERSTAND THE FINANCIAL OBLIGATION ATTACHED TO THIS PROCEDURE AND AGREE TO COMPLY AS LISTED BELOW:
AMOUNT DUE __________ TO BE PAID IN __________ MONTHLY PAYMENTS OF $__________ STARTING __________.
BALANCE TO BE PAID IN FULL BY __________.

I UNDERSTAND THAT I AM RESPONSIBLE FOR <u>ALL</u> FEES REGARDLESS OF INSURANCE COVERAGE. I ALSO UNDERSTAND THAT AS TREATMENT PROGRESSES THE ABOVE FEES MAY HAVE TO BE ADJUSTED, BUT THAT I WILL BE INFORMED OF THESE ADJUSTMENTS AND HOW THEY WILL AFFECT MY PAYMENT PLAN. IN THE EVENT THAT MY PAYMENTS ARE NOT RECEIVED WITHIN 30 DAYS OF THEIR DUE DATE, I AGREE TO PAY ALL COSTS OF COLLECTIONS, INCLUDING, BUT NOT LIMITED TO, REASONABLE ATTORNEY'S FEES.

I CONFIRM THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE AND THAT ALL BLANK SPACES HAVE BEEN COMPLETED PRIOR TO MY SIGNING.

I HEREBY CONSENT TO THE PROPOSED DENTAL TREATMENT.

______________________________ ______________
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR DATE

______________________________ ______________
INTERPRETER (IF USED) DATE

______________________________ ______________
SIGNATURE OF WITNESS DATE

DENTIST CERTIFICATION:

I HEREBY CERTIFY THAT I HAVE EXPLAINED THE NATURE, PURPOSE, BENEFITS, RISKS OF, AND ALTERNATIVES (INCLUDING NO TREATMENT AND ATTENDANT RISKS), TO THE PROPOSED PROCEDURE(S). I HAVE OFFERED ANSWERS TO ANY QUESTIONS AND HAVE FULLY ANSWERED ALL SUCH QUESTIONS. I BELIEVE THAT THE PATIENT/PARENT/GUARDIAN FULLY UNDERSTANDS WHAT I HAVE EXPLAINED AND ANSWERED.

DENTIST'S SIGNATURE ______________________________

PRINT NAME ______________________________ DATE ______________

ITEM 27005

____
PATIENT NUMBER

CONSENT TO DENTAL TREATMENT

Arbor Place Dental Group

To Our Patients:

Our mission is to deliver the highest quality of dental care in a warm and friendly environment. To accomplish this, we schedule each patient a according to his or her personal needs. In order for our staff to provide each patient with the level of care needed, please observe the following appointment cancellation policy.

- A **48**-business hour business notice is required for canceling appointments. Failure to give a **48-hour** notice will result in a broken appointment fee of **$50.00** for each hour of your appointment(s)

- A member of our office staff will call to confirm your appointment time. **Failure** to confirm appointment can result in cancellation of your appointment.

- If you are more than **15 minutes** late for an appointment, we reserve the right to reschedule your appointment.

- Your signature indicates understanding and acceptance of the above policy.

__________________________________(Patient/Guardian if under 18)

__________________________________(Date)

2976 CHAPEL HILL, SUITE 300 DOUGLASVILLE, GA 30135 TELEPHONE (678) 838-9600