BETHLEHEM TOWN
FAMILY DENTAL

Patient Consent

I hereby authorize and provide consent to the staff members and the doctors of Bethlehem Town Family Dental to:

- Take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.
- Photos taken can be used on practice's website under Before and After gallery, photos posted will show mouth and teeth only, no other facial features will be visible.
- Perform any and all forms of treatment, therapy, and administration of medications that may be indicated and is deemed appropriate.
- Use anesthetic agents, such as local anesthetics and nitrous oxide gas, and understands anesthetic agents embodies a certain risk.
- Discuss consents, treatments, financial information, and account information over the phone.
- Request medical information, medical clearance, radiographs, and clinical records on my behalf from other medical and dental facilities.
- Be assigned as the provider to receive payment from my group insurance benefits.

I hereby acknowledge and agree that:

- Responsibility for payment of dental services provided in this office for myself and my dependents is payable at the time services are rendered. In the event of default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to collect.
- During the procedure(s), unforeseen conditions may arise and additional procedure(s) or change(s) to current procedure(s) may be required as deemed appropriate by the professional judgement of the doctor. I understand that any additional payment resulted from the unforeseen conditions will be my responsibility.
- Any difference between insurance estimate and reimbursement will be my responsibility. Examples of differences include, but not limited to, insurance downgrades of crowns and fillings, change of coverage, deductibles, and co-payment.
- Cellphones and cameras are NOT permitted in the treatment area as required by HIPPA regulations. Please consult with our staff if you wish to take a photograph or talk on the cellphone in the clinical area.
- Appointments made are reserved exclusively for me and I will notify the office 48 hours in advance if I can't keep the appointment.

Print Patient Name:_____

Patient Signature:_____

Parent / Guardian Signature:_____

Date:_____