# PATIENT CONSENT

## Clinical

1. I authorize **Spencer Family Dental** to perform all recommended treatment mutually agreed upon by me.

2. I authorize the practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "diagnostic material") as needed to make a thorough diagnosis. I authorize that such diagnostic material may be released to third-party payors and/or other health professionals.

3. I authorize the use of anesthetics, sedatives, and other medication, as needed. I am fully aware that using anesthetic agents involves certain risks including, but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

## Financial

4. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a billing fee will be automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

5. A fee may apply for failed appointments or appointments cancelled with less than two working days notice.

## Insurance

6. I authorize the practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other diagnostic material about my medical history, services rendered, or recommended treatment.

7. I authorize the practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

**I have read this Patient Consent and agree to all terms and conditions herein.**

Patient's Name:_____ Date_____

Patient's Signature _____

Patient's Address _____

Witness Signature _____