PATIENT CONSENT (MINOR)

Clinical

1. As the parent/legal guardian of _____I authorize **Spencer Family Dental** to perform all recommended treatment on the patient that is mutually agreed upon by parent or guardian.

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 behalf of the patient. 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

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 the patient's 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 or on the patient's 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:_____
DOB_____

Signature of Parent/Guardian_____Date_____

Relationship to Patient _____ Address _____

Witness Signature _____