1504 Wayne Memorial Drive, Goldsboro, NC 27534 919-735-3431

200 North Leslie Street, Goldsboro, NC 27530 919-581-9300

CONSENT FOR TREATMENT

1. I hereby authorize the doctors of this practice & designated staff to take x-rays study models, photographs, and other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of my dental needs.

2. Upon diagnosis my doctor will present to me a treatment plan and options I authorize perform all recommended treatment mutually agreed upon as designated by my signature on the agreed upon plan, I also agree to employ such assistance as required to provide proper care including keeping appointments and scheduling regular follow up appointments as recommended by my doctor.

3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks, I understand that I can ask for a complete recital of any possible complications.

***4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of services unless other arrangements have been made. My claims will be filed as a courtesy however, all estimates of insurance benefits from my insurance company are ONLY an estimate and cannot be guaranteed, and I understand that any outstanding balance denied by the insurance company is my responsibility.**

5. I understand that my medical history information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you may have my permission to ask the respective health care provider or agency, who may release such information to you and I will notify this office of any changes in my health or medical conditions.

6. As required by HIPAA I have been given an opportunity to read the Notice of Privacy Practices for this office, by signing this consent I agree and understand how my personal health information will be shared; I understand that I may request a written copy of these practices at any time.

7. I agree to photography, filming, recording, x-rays, and additional professional staff observing the procedure performed for the advancement of dentistry and testimonials.

PRINT NAME_____ DATE:_____

SIGNATURE_____ DATE_____