CONSENT FOR TREATMENT

I authorize *Dr. Goldberg D.D.S* and/or assistants as s/he may designate to perform those procedures that may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause a reaction or side effects, which may include, but are not limited to bruising, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may in rare cases, require bronchoscope or other procedures to ensure safe removal. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

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Initials

HIPAA PATIENT CONSENT

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent, in writing. The practice provides this form to comply with the Health Insurance Portability Accountability Act 1996 (HIPPA). A detailed description of the HIPAA policy is available for you upon request.

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Initials

OFFICE FINANCIAL POLICY

1. Our office provides insurance claim submission as a courtesy to our patients. You are directly responsible to for any unpaid balance by your insurance. A service charge of 1 1/2% per month (18% per annual) on the unpaid balance will be assessed on all accounts exceeding thirty (30) *days* from the date of service Deductibles, co-payments, or non-insured patient payments are due upon date of service.

2. I understand that a **$50.00 no show/cancellation fee** may be applied to my account for a missed appointment or failure to give a 24 hour cancellation notice.

I understand the following: I agree that failure to make a payment will result in my account being sent to a collection agency. All payments must be then made to the collection agency. I agree to pay the collection agency fees of 33% of the balance along with my balance and other additional costs including attorney fees and court costs.

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Patient or Guardian Signature Date

**Please give a name(s) of a person(s) that has your permission to talk to us about your account, or appointments on your behalf if needed. **

#1_____ #2 _____