CONSENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of _____'s dental needs.
   (name of patient)

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by myself and the doctor and to employ such assistance as required to provided such recommended treatment.

3. I consent to the use of appropriate medication and therapy as deemed necessary by the doctor after the consultation with me. I fully understand that using anesthetic agents embodies a certain risk.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents, whether or not the services are covered by insurance. I understand that payment is due at the time of service unless other arrangements have been made prior to the time of service. In the even payments are not received by agreed upon dates and prices, I understand that an 18% finance charge per month will apply to the remaining balance.

5. In the event that my account is referred to an attorney for collection, then I agree to pay attorney's fee of 33 1/3% and all court costs incurred during the collection of my delinquent account in addition to the amount owed by me.

PATIENT _____ DATE _____

PARENT/RESPONSIBLE PARTY _____

RELATIONSHIP TO PATIENT_____