RITA MEDWID DDS, PA
DENTAL HEALTH SPA

Acknowledgement of Receipt of Notice of Privacy

I,_____, have received a copy of this office.s Notice of Privacy Practices.

_____
Print Full Name

_____ _____
Signature Date

Consent for Treatment

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

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication 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.

Patient_____ Date_____ Witness_____

Parent or Responsible Party_____ Relationship to Patient_____

Fees and Payments

Payment is expected upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you before treatment. If you have any dental and/or medical insurance, we will be glad to fill out the proper forms but please complete the identifying information on the front of the form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance company

Patient_____ Date_____ Witness_____

Parent or Responsible Party_____ Relationship to Patient_____

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