Patient Consent for Treatment and Guidelines

_____ I hereby authorize Dr. Perona or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs for proper dental care.

_____ I agree to the use of anesthetics 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.

_____ I request and authorize Dr. Perona to do whatever he deems advisable if any unforeseen condition should arise in the course of procedures I may need.

_____ Upon diagnosis, I authorize Dr. Perona to perform all recommended treatment mutually agreed upon by me and to employ such assistance to provide proper care.

_____ I have advised Dr. Perona of any pre-existing medical conditions, medical complications I have experienced and all current medications and supplements.

_____ I have advised Dr. Perona if I am undergoing any current treatment for any purpose.

_____ Should Dr. Perona refer me to a specialist. I authorize the release of any information concerning my health care, advice for treatment to another dentist/specialist.

_____ I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

_____ I understand that my dental plan or payer of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible, in full, for all services provided. I revoke all previous agreements to the contrary and agree to be responsible for payment for services not paid, in whole or part by my dental care plan.

_____ I hereby authorize payment of dental plan benefits directly to the dentist. Otherwise payable to me.

_____ I agree to be responsible for payment, in full, of all services rendered on my behalf. I understand that payment is due at the time services are provided unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.67% finance charge (20% APR) will be added to my balance.

Payment forms accepted include cash, check, or credit cards from Visa, MasterCard, or Discover.

_____ I understand that a scheduled dental appointment is my commitment to the office and to my doctor. I agree to be responsible for the broken appointment fees for cancelling with less than 2 days (48 hours) notice or “no show” appointments.

Proper notification will avoid a cancellation fee of $185.

Patient Name (please print): _____

Signature: _____ Date: _____
Witness: _____