PATIENT CONSENT FOR TREATMENT

1. I do authorize and give consent to the doctor and his/her staff to administer treatment, including but not limited to: local anesthesia, analgesia, and other such treatment which, in their judgment, may be necessary for the prudent exercise of medical or dental care. I understand that the use of medications, anesthetics and some procedures embody certain risk.

2. I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.

3. I consent to the disposal of any tissues or body parts that may be removed.

4. The attached medical and dental history was completed fully and accurately, to the best of my knowledge.

5. I understand and agree that a routine credit check from Equifax will be processed at the discretion of Foulk-Manela Pc.

6. I understand that responsibility for payment for dental services provided in this office for myself or my dependent is mine. Unless other arrangements are made prior to treatment, accounts are to be paid on the day services are provided.

7. I hereby authorize and direct my insurance company to pay a benefit due to me directly to this office. In the event of legal action on this account, I agree to pay any and all costs of such suit, collection and attorney fees.

8. A service charge of 1.5% per month (18% per annum) will be added to the unpaid balance of all accounts not paid in full within 90 days of the treatment date.

9. I grant my permission to you or assigns to telephone me at home or at my work to discuss matters related to this consent, my treatment, or my account.

_____
Patient Name (Print or Typed)

_____ _____
Signature of Patient or Responsible Party Date

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