West River Dental Family & Cosmetic

Patient Consent

1. I do authorize and give consent to West River Dental, the Dentist and his staff to administer treatment, including but not limited to local anesthesia 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 a certain risk.
2. I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be attained.
3. I understand that during the procedure(s) unforeseen conditions may arise that necessitate different procedures from those planned. I consent to the performance of additional procedures that are deemed necessary in the professional judgment the dentist and I understand that payment for these additional procedures is my responsibility.
4. I consent to the disposal of any tissues or teeth that may be removed.
5. The attached medical and dental history was completed fully and accurately to the best of my knowledge.
6. I understand the responsibility for payment of dental services provided in the office for myself or my dependent is mine. Accounts are to be paid on the day services are provided. Any account that is 60 days or over will be sent to the company we use to collect outstanding balances. You will then receive correspondence from Transworld collection services.
7. I hereby authorize payment of my group or individual insurance benefits, otherwise payable to me, to West River Dental. In the event of legal action of this account, I agree to pay any and all costs of such suit, collection and attorney fees. I have reviewed the treatment plan and authorize the release of any information relative to this claim.
8. A service charge of 1.5% per month will be added to the unpaid balance of all accounts not paid in full.
9. I grant my permission to you or your assignees to telephone me at home or at my work to discuss matters related to this consent, my treatment or my account.
10. I understand that if I am unable to keep my appointment, as a courtesy, I need to let WRD know at least 24 hours in advance.
11. If anyone else needs to be involved in scheduling your appointments or discussing your treatment please sign our permission form.
12. I acknowledge the receipt of the notice of Privacy Practices and authorize the release of identifying health information. I have had the opportunity to review and accept West River Dentals patient consent form and office policies.

_____ _____

Patient name (print) Date

_____ _____

Signature of Patient or responsible Party Relationship (if responsible party)