PHILLEY DENTISTRY

I_____, consent to be a patient at the Philley Dentistry and agree to a radiographic and clinical examination. I also understand and consent to the following:

- I will strive to make all dental appointments and understand a fee may be applied if I fail to show without a 24-hour notice.
- During the course of treatment, I may undergo procedures in all phases of dentistry.
- I will provide a thorough and complete medical history and supply a full list of my medications with dosages.
- No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that dental treatment can involve unanticipated results.
- I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for any costs that my insurance does not cover.
- My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist and office staff.
- I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.
- I authorize the release of pertinent information between medical, dental and insurance companies.
- I have received a copy of the office's Notice of Privacy Practices.

_____ _____

Patient or Guardian Name Date