STAHL DENTAL STUDIO

Consent for Treatment

1. I hereby authorize Stahl Dental Studio to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Stahl Dental Studio to make a thorough diagnosis of _____'s dental needs.

2. Upon such diagnosis, I authorize Stahl Dental Studio 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 anesthetic, sedatives and other medication as and if 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.

4. I give consent to Stahl Dental Studio's use and disclosure of any oral, written or electronic health records that are individually identifiable as me for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service, unless other arrangement have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made. In the event the balance is not paid in full after a reasonable amount of time, I understand that all collection costs and attorney's fees associated with the collection of the outstanding balance will be my responsibility.

_____
DATE

_____
RESPONSIBLE PARTY'S SIGNATURE

_____
RESPONSIBLE PARTY'S NAME

_____
RESPONSIBLE PARTY'S RELATIONSHIP TO PATIENT

_____
WITNESS

Thank you!