PENINSULA
DENTAL CARE

RAMIZ R. PETROS, D.M.D
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CONSENT FOR TREATMENT

1. I hereby authorize Dr. Petros and designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (Name of the Patient)_____'s dental needs.

2. Upon such diagnosis, I authorize the doctor 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 medications 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.

4. I give consent to the doctor or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and healthcare 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 dependants. I understand that payment is due at the time of service unless other agreements have been made. In the event of payments are not received by agreed upon dates, I understand that 2.5% late charge may be added to my account, also I understand that in the event full payment is not made within 90 days my account will be forwarded to collection. I also understand a check of my credit history may be made.

6. I understand and agree to be fully responsible for any medical bills, dental bills, lab fees, or medication cost rendered outside Peninsula Dental Care office of Ramiz R. Petros D.M.D Inc.

_____

Signature of Patient or Responsible Party Date

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Witness Date