

ANNA LEE, D.D.S.
410 South Glendora Ave., Suite 210
Glendora, CA 91741
626-335-5114

CONSENT FOR TREATMENT

1. I hereby authorize Dr. Anna Lee or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize Dr. Anna Lee 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 anesthetics, sedatives and other medication 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 agree to be responsible for payment of all services rendered on by behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.
5. Dental Insurance-We have found that insurance benefits generally cover 50% to 80% of the total fee. Accordingly, we ask that you pay your estimated portion of the charge for the treatment provided at the time of your appointment. We cannot guarantee payment of your claims. If your insurance company pays only part of the bill or rejects your claim, any contact or explanation should be made by you and to you, their policyholder. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.
6. Office Policy: A \$50.00 Office Fee will be charged to your account for missed appointment or cancellation without prior 24 hours notice.

Patient's Signature _____ Date _____

Witness _____

Parent/responsible Party's signature _____

Relationship to Patient _____