

Consent for Treatment

1. I hereby authorize Doctor Oshins 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 Doctor Oshins 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 my 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% (18% APR) may be added to my account. I also agree to pay any legal interest on the balance due together with any collection costs and attorney fees incurred in the attempt of collection of this account.

Patient's Signature: _____ Date: _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____.

Expectations Regarding Appointments

To Our Patients:

We work very hard at treating our patients as unique individuals. We try to remain responsive to each person's needs, preferring to rely on common sense and common courtesy rather than hard and fast "policies". **Unlike many dental practices where the dentist bounces from room to room, we only see one patient at a time. When you book an appointment with us, you have our undivided attention for the length of that appointment.**

Short notice cancellations or missed appointments effect many people. From an operations standpoint, missed appointments increase our cost of providing dental care – costs that ultimately must be passed to you, our patient. More importantly, missed appointments do not allow us the opportunity to offer the appointment time to other patients needing- and wanting- care.

For these reasons we are asking you to read and agree to these expectations:

1. Please respect our time and that of other patients by giving us a minimum of two business days (Monday-Thursday) notice to cancel or change an appointment.
2. For Cancellations or missed appointments where less than two business days' notice is given, a 50-100 dollar charge will be applied to your account.

Such policies have been standard practice for other health care providers who work one-on-one with their patients. We thank you in advance for your understanding.

Signed: _____ Date: _____