Dentistry with a Smile, LLC

Dr. Suhair Shamoon

Patient Consent

1. I do authorize and give consent to the Dentist and his/her staff to administer treatment, including but not limited to local anesthesia and other such treatment, which, in their judgment, may be necessary for the prudent exercise of medical or dental care. I understand that the use of medications, anesthetics and some procedures embody a certain risk.
2. I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.
3. I understand that during the procedure(s) unforeseen conditions may arise that necessitate different procedures from those planned. I consent to the performance of additional procedures that are deemed necessary in the professional judgment the dentist and I understand that payment for these additional procedures is my responsibility.
4. I consent to the disposal of any tissues or body parts (teeth) that may be removed.
5. The attached medical and dental history was completed fully and accurately to the best of my knowledge.
6. I hereby authorize payment of my group insurance benefits, otherwise payable to me, to **Dentistry With A Smile, LLC**. In the event of legal action of this account, I agree to pay any and all costs of such suit, collection and attorney fees. I have reviewed the treatment plan and authorize the release of any information relative to this claim.
7. I grant my permission to you or your assignees to telephone me on any and all contact numbers provided to **Dentistry With A Smile, LLC** to discuss matters related to this consent, my treatment or my account.
8. I have had the opportunity to review **Dentistry With A Smile, LLC** Notice of Privacy Practices.
9. I understand that if I am unable to keep my appointment, I need to let **Dentistry With A Smile, LLC** know at least **24 hours** in advance. I also understand **Dentistry With A Smile, LLC** reserves the right to assess at a minimum a fee of **$40** for late cancellations and/or missed appointments.
10. I understand responsibility for payment of dental services provided in this office for me or any and all dependents is mine. **Unless other arrangements are made prior to treatment, co-insurances and applicable deductibles are to be paid on the same day services are provided.** I have read and I understand **Dentistry With A Smile, LLC** financial policy.

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Patient Name (Print or Type) Date

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Signature of Patient or Responsible Party Relationship (if responsible party)