PINNACLE
DENTISTRY
-CO SPRINGS-

Consent For Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis including consultation with adjunct healthcare providers as he deems necessary.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance, including other healthcare providers, 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 understand that each appointment I will have is set-aside specifically for me. If I am more than 10 minutes late I may not be seen. If I fail to notify Pinnacle Dentitry staff more than 24 hours ahead of time of canceling an appointment or do not arrive for an appointment, a broken appointment fee of $45.00 may be assessed.

5. When and if I ever receive a prescription for a controlled substance (narcotic drug to help with my pain), certain prescription information, including my name, will be entered into a secure database called the Colorado Prescription Drug Monitoring Program. Only authorized individuals, like healthcare personnel that prescribe controlled substances and law enforcement under very limited circumstances, can access the database and only for tightly defined uses. The database is used to help prevent inappropriate use of controlled substances– like fraud and abuse.

6. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. It is my responsibility to know my insurance benefits and plan parameters, and I will be responsible for telephoning them myself, should I have any questions. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand my insurance carrier may pay less than the actual bill for services. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received as agreed upon, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

_____ _____
Patient Signature Date

_____ _____
Parent or Responsible Party Relationship to Patient