GENE HASSELL D.D.S.
GENERAL & COSMETIC DENTISTRY
200 WEST MAIN STREET | PFLUGERVILLE, TX 78660
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512.251.7503

## CONSENT FOR TREATMENT

1. I hereby authorize Dr. Hassell or his ..designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Hassell to make a thorough diagnosis of (your name)________________________________'s dental needs.

2. Upon such diagnosis and discussion of treatment and fees, I authorize Dr. Hassell to perform all recommended treatment that has been 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 review of any possible complications.

4. I give consent to the doctor's 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 health care 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 dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event that 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.

Patient's Signature ______________________________ Date _____________ Witness_____________

Parent/Responsible Party's Signature ____________________________ Relationship to Patient__________