Reed Family Dental

Lyssa A. Reed D.D.S.

Consent for Treatment

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of _____ (name) dental needs.

2. Upon such diagnosis, I authorize the doctor 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 medications 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 all 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 1-1.5% late charge (18% APR) may be added to my account. If failure to pay account in timely matter I am aware that my account could be sent to collections where my credit history will be check by collection agency used by our office.

Patient's Signature _____ Date _____

Parent/Responsible Party's Signature_____ Date _____

Relationship to patient_____

870 W Onstott Rd, Suite B Yuba City, CA 95991 530-671-2580