Scott I Rothbart DDS

1223 N. Providence Rd.
Media, PA 19063
610-566-5555
www.DrRothbart.com

Consent for Treatment

1. I hereby authorize Scott I. Rothbart, D.D.S. or designated staff member to take radiographs (x-rays), study models, photographs, or other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of the patient's needs.

2. Upon such diagnosis, I authorize the dentist or designated staff member 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, or 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 give consent to the dentist 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. I have been given the Notice of Privacy Practices that outlines the protection of my personal health information.

5. I agree to be responsible for payment of ALL services rendered on my behalf or of 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 1.5% late charge (18% APR) may be added to my account balance. If required, I also understand a check of my credit history may be made.

Patient's Name (printed): _____

Patient or Guardian's Signature: _____

Date: _____