William Holmes DDS **Dan Mannikko DDS**
Emily Beglin DDS

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's to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommmended treatment mutually agreed upon and to employ such assistance as required to provided 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 to any possible complications.

4. I understand that payment is due at the time of service, as a courtesy, we will submit claims to your insurance company. Predeterminations are not a guarantee. If you find it necessary to cancel or not show up for an appointment without 24 hour notice then there will be a charge applied.

5. FINANCIAL ARRANGEMENT: Should payment arrangements become necessary, I will comply with arrangements made and fully understand that if my account balance (regardless of insurance status) goes past 90 days, a monthly service charge of 1.83% (22% APR) will be assessed on that balance and added to my account.

Patient Signature_____Date_____

Parent or Responsible Party Signature_____

Relationship to Patient_____

HIPPA PRIVACY POLICY

Our office is fully comitted to compliance with HIPPA guideline by:

1. Providing appropriate SECURITY for our records.
2. Protecting the PRIVACY of our patients medical information.
3. Providing our patients with proper ACCESS to their medical records, once a signed release is obtained.
4. Appropriately maintaining our patient information and billing process in compliance with national HIPPA STANDARDS.
5. Not providing patient data to marketers or pharmaceutical companies for purpose of research.

I acknowledge that I have read and understand the privacy policy of William Holmes, Dan Mannikko, and Emily Beglin.

Patient Signature_____Date_____

Parent or Responsible Party Signature_____

Relationship to Patient_____