Patient Consent

1 A.I authorize Todd S. Klein, D.D.S. to perform all recommended treatment.
B. **(FOR MINORS)** as the parent/legal guardian of _____
(Minor Patients Name)
I authorize Todd S. Klein, D.D.S. to perform all recommended treatment on the Patient.

2 I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Materials may be released to third party payers and /or other health professionals.

3 I authorize the use of anesthetics, sedatives, and other medications as needed, and I am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and /or lack of coordination.

4 I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. Should my account become delinquent, I will be responsible for all additional collection costs, reasonable court costs, interest, and legal fees should it become necessary.

5 As a courtesy to our other patients, we request at least a 24 hour days' notice when rescheduling appointments. Thank you

6 I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers of their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.

1. **Name** _____
Please Print Name of Patient or Guardian If Minor

2. **Signature** _____ **Date:**_____