ADVANCE CONSENT TO TREAT MY CHILD/DEPENDENT

As the parent or legal guardian of _____, I hereby authorize and consent dental treatment to be performed for my child by the licensed dental care providers at Simply Smiles dental practice in Auburn, Washington.

I understand that dental treatment needs can change once treatment commences, necessitating changes in costs and procedures. If my minor child drives themselves or a sibling to their dental appointments, I will not be present.

As a result, I understand and agree to one of the following options whenever treatment is to be provided to my minor child/dependent.

CHOOSE A or B:

A. **I DO NOT authorize** my child's dental care providers to make any changes to the previously discussed and agreed to treatment without my permission. **I agree to be physically present in the office during ALL dental appointments, including preventative visits, in order to receive any diagnosis and treatment plan changes prior to granting consent for continuing treatment.** Initials_____

B. **I DO authorize** **my child's dental care providers, when necessary and in the best interests of my child, to add to, delete or modify any treatment planned for that day's appointment.** I hereby waive my right to a new informed consent discussion for any treatment changes. I understand that an attempt will be made to contact me at the phone numbers I have provided, before proceeding with treatment changes. **As a result of providing this Advance Consent to treatment changes, I will not be required to be physically present during my child's dental treatment visits.** Initials_____

This authorization will remain in effect until revoked in writing by me. I understand and accept that I am financially responsible for the costs of all treatment provided.

As the parent or legal guardian of the above named child, I have read and agree to the above:

Signature_____ Date_____ Staff_____

Please email this form to admin@simplysmilesauburn.com before your child's next appointment