

Evergreen Dentistry

Laura Howrey, DDS

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Consent

I, the undersigned, hereby authorize the Doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs.

I authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the Doctor employs any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others who may request my records.

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees.

I understand that payment is due when services are rendered. Any other arrangement for payment must be made *before* treatment begins.

Date: _____

Patient Signature/legally authorized representative

Date: _____

Printed Name if signed on behalf of the patient