LISA GITELSON, DMD, PC
14300 S.W. PACIFIC HWY.
TIGARD, OR 97224
(503) 639-4330

As the parent of _____ / _____,
(Patient's Name) (Birth Date)

I hereby accept responsibility for payment of any services performed by the office of Lisa Gitelson, DMD, PC, for him/her. After the course of treatment has been paid in full, and I no longer wish to accept responsibility for future treatment, I will so inform the doctor's office in writing.

_____
(Parent/Responsible Party's Printed Name)

_____
(Parent/Responsible Party's Signature)

_____
(Address 1)

_____
(Address 2)

_____
(Date)