PATIENT AUTHORIZATION FOR SERVICES

I hereby authorize doctor or staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of __________________'s dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required in providing proper care. I agree to the use of anesthetic and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks, and that I can ask for complete recital of any possible complications.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I __________________, acknowledge that I have been made aware of Adel Dental Group's Notice of Privacy Practices. This notice describes how the doctor may use or disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

I hereby grant access to my dental information to the following individual(s):

Person	Relationship
Person	Relationship

PATIENT PAYMENT FOR SERVICES AGREEMENT

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that I shall be responsible for any and all expense incurred at this office, and I understand that payment is due at the time of services, unless other arrangements have been made, regardless if I have insurance. In the event payments are not received by the agreed upon dates, I understand a finance charge of 18% APR may be added to my account.

Adel Dental Group values the time for each appointment scheduled at our office. We appreciate a notification of 2 days prior to any appointment cancelation. Please be advised, a fee may be applied for cancelations less than 24 hours prior to the scheduled appointment.

TO BE SIGNED AT YOUR VISIT

Signature:_______________________________________ Date:_______________________