8301 Magnolia Estates Drive
Suite 4
Cornelius, NC 28031
www.corneliusdentistry.com
704 / 896.7660

Consent for Treatment:

- I hereby authorize Cornelius Dentistry staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by Cornelius Dentistry staff to make a thorough diagnosis of (name of patient) _____'s dental needs.
- Upon such diagnosis, I authorize staff of Cornelius Dentistry to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Financial Policy

- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account.
- I authorize the submission of dental claims to my insurance company on my behalf or my dependents'. I understand that the amount paid by my insurance may vary depending on the policy with which I am enrolled and that I will be responsible for payment of any balance therafter.

Cancellation Policy

- I understand that without a courtesy call at least 2 business days prior to canceling or changing an appointment, a $85.00 to $100.00 charge will be added to my account.

Patient/Responsible Party Signature_____ Date_____

Witness_____ Date_____