INFORMED CONSENT

I will be informed of an estimate of the treatment planned, procedures involved and associated fees. Treatment diagnosed will be based on X-ray and clinical examination only. Procedures may change during treatment due to unforeseen conditions including nerve damage, decay, infection, fractures and any other conditions. You will be advised of any such change, and fees may change as a result. This change would be the responsibility of the patient.

I have disclosed my health history information, including allergies, reactions to medicines, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I will be presented with the risks, benefits and alternatives of treatment and will have the opportunity to have my questions answered and concerns addressed. I understand that treatment is not a guarantee to save all teeth and restorations, and that complications can occur from treatment.

To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with insurance claims. I agree to be responsible for all charges for dental services and materials, not paid by my dental benefit plan. I hereby authorize and direct payment of dental benefits otherwise payable to me, directly to Narita Family Dental. I understand that insurance benefits are not a guarantee of actual payment and I will be responsible for any difference between the office fees and insurance payments. A pre-determination of insurance benefits, especially for major treatments are recommended.

I confirm that I understand this form and the information contained herein. I give consent for myself/my child to receive dental treatment deemed necessary by providers at Narita Family Dental.

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Patient Name Signature Date