80 Eastern Ave Unit 1
Brampton ON L6W 0B6
Phone: 905-450-7272
Fax: 905-450-9602
Email: info@hansendental.ca

PATIENT CONSENT FOR TREATMENT

I certify that I have read and understand the Patient Medical Form and that it is accurate and true to the best of my knowledge and I have not omitted data. I consent to the release of medical information from my medical doctor as is required by this dental office.

I understand that all dental treatment will be explained to be before performed and hereby authorize my dentist to provide the dental treatment I require. This includes the taking of x-rays and the administration of necessary anesthetics and medications.

_____ _____

Signature of Patient or Parent/Guardian Date

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practise depends on reimbursement from patients for the costs incurred in their care. Financial responsibility of treatment rendered to the patient is the responsibility of the patient and must be paid on the date of service, either by assignment of benefits from the patient's insurance carrier or by the individual patient. If at any time dental services are said to be covered by the insurance carrier and are not, it will therefore be the responsibility of the patient.

All emergency dental services or any dental services performed without previous financial arrangements must be paid for at the time services are performed unless other arrangements have been made.

Patients with non-assignment dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for dental care can be only extended for a period of six months from the date of the patient examination unless arrangements have been made and authorized by the doctor or office manager.

In consideration for the professional services rendered to me by this practise, I agree to pay the charges for the services at the time of treatment, unless other arrangements have been made and authorized by the doctor or office manager.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I have read the above conditions of treatment and payment and agree to their content.

_____ _____

Signature of Patient or Parent/Guardian Date