Hawk
DENTAL ARTISTRY

CONSENT FOR TREATMENT

1. I hereby authorize Dr. Ronald Hawk and/or designated staff to take x-rays, study models, photographs, and other diagnostics as deemed appropriate by doctor to make a thorough diagnosis of (*name of patient*) _____'s dental needs.
2. Photography Models Release: I, _____, hereby authorize Dr. Ronald Hawk or designated staff to take photographs, slides and/or videos of my face, jaws, and teeth.
3. _____ (*initials)* I understand that photographs, slides, and/or videos will be used as a record of my care. These may be used for educational purposes in lectures and demonstrations. They may also be used in advertising (including website publication, newspapers, magazines, and journals). These images may include full face portraits and close-up views of teeth.
4. _____ (*initials)* I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.
5. Upon diagnosis, I authorize Dr. Ronald Hawk to perform any recommended treatment, mutually agreed upon by me and to employ such assistance as required to provide proper care.
6. 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.
7. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of taking care of my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed, and that a notice fully outlining the protection of my personal health information is available.
8. 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 1-1/2% per month late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Print Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

_____
Witness

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