

CONSENT FOR TREATMENT

- 1) *I authorize Dr. Coulter or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by Dr. Coulter to make a thorough diagnosis of (name of patient)_____’s needs.*
- 2) *Upon such diagnosis, I authorize Dr. Coulter to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.*
- 3) *I agree to the use of anesthetic, 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.*
- 4) *Lastly, 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 date, I understand that a 1 ½% late charge (18% APR) may be added to my account.*

PATIENT:_____ **DATE:**_____

PARENT OR RESPONSIBLE PARTY:_____

RELATIONSHIP TO PATIENT:_____