# WENDEL FAMILY DENTAL CENTRE
## Patient Consent

1. I do authorize and give consent to WFDC, the Dentist and his/her staff to administer treatment, including but not limited to local anesthesia and other such treatment, which, in their judgment, may be necessary for the prudent exercise of medical or dental care. I understand that the use of medications, anesthetics and some procedures embody a certain risk.

2. I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.

3. I understand that during the procedure(s) unforeseen conditions may arise that necessitate different procedures from those planned. I consent to the performance of additional procedures that are deemed necessary in the professional judgment the dentist and I understand that payment for these additional procedures is my responsibility.

4. I consent to the disposal of any tissues or body parts that may be removed.

5. The attached medical and dental history was completed fully and accurately to the best of my knowledge.

6. I understand and agree that a routine credit check from Equifax will be processed at the discretion of Wendel Family Dental Centre. **If you would prefer to pay date of service and not have a credit check performed, please initial here _____.** We will request payment in full **(cash or credit)**.

7. I understand responsibility for payment of dental services provided in this office for myself or my dependent is mine. Unless other arrangements are made prior to treatment, accounts are to be paid on the day services are provided. I have read and I understand Wendel Family Dental Centre's financial policy.

8. I hereby authorize payment of my group insurance benefits, otherwise payable to me, to Wendel Family Dental Centre. In the event of legal action of this account, I agree to pay any and all costs of such suit, collection and attorney fees. I have reviewed the treatment plan and authorize the release of any information relative to this claim.

9. A service charge of 1.5% per month (18% per annum) will be added to the unpaid balance of all accounts not paid in full within 90 days of the treatment date.

10. I grant my permission to you or your assignees to telephone me at home or at my work to discuss matters related to this consent, my treatment or my account.

11. I have had the opportunity to review Wendel Family Dental Centre's Notice of Privacy Practices.

12. I understand that if I am unable to keep my appointment, I need to let WFDC know at least 48 hours in advance. **I also understand Wendel Family Dental Centre reserves the right to assess a minimum $30 fee for late cancellations and/or missed appointments.**

_____ _____

Patient Name (Print or Type) Date

_____ _____

Signature of Patient or Responsible Party Relationship (if responsible party)