Treatment Authorization and Acknowledgement

Patient Name (Please Print): _____

I, the above mentioned patient consent to treatment as necessary or desirable for diagnosis of dental disease, deformity, or treatment of dental pathology and emergencies. These procedures may include radiographs, models, and intraoral examinations. In the case of a dental emergency, I consent to treatment as deemed necessary by Dr. Roxy Georgescu, understanding that the procedure will be explained in advance.

I give my consent to the use of local anesthetic and relaxants for completing the necessary dental treatment.

I also acknowledge full responsibility for the payment of such services and agree to pay in full unless I have insurance coverage, whereas I will pay my portion at time of service. I further understand that a finance charge may be added to my overdue balance, and I am also subject to collection and/or legal recourse if my balance remains past due. I have been informed that any appointment made for myself or a family member is reserved for me/family member and unless I notify this office 24 hours in advance of a need to reschedule, I am subject to a $75 per hour cancellation fee.

Patient Signature_____ Date _____