CONSENT FOR TREATMENT & FINANCIAL RESPONSIBILITY

Gordon A. Bech, DDS
925 Cross Gates Blvd.
Slidell, LA 70461
985-641-4180

Please read and initial each item, then sign and date at the bottom.

_____ 1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

_____ 2. Upon such diagnosis, I authorize doctor 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 anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risk. I understand that I can ask for a complete recital of possible complications.

_____ 4. I agree, upon signing, that Dr. Bech will file for payment with my insurance provider and payments will be mailed directly to him. I understand that a quote of benefits by my insurance provider is not a guarantee of payment on their behalf and that ultimately any balance is my sole responsibility.

_____ 5. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents, regardless of stated insurance coverage. I understand that payment is due at the time of service unless other arrangements have been made.

Patient: _____ Date: _____ Witness: _____

Parent or Responsible Party: _____ Relationship to Patient: _____