Consent For Treatment

North Michigan Avenue Dental Group

Sanya Kirovski D.D.S. & Maryann V. Kelly D.D.S.

845 N. Michigan Ave., # 953W, Chicago, IL 60611

(312) 337-3543

http://www.bestcosmeticdentistchicagoil.com

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my 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, sedative, and other medication as necessary. I fully understand that using anesthetic agents embody certain risks. I understand that I can ask for a complete recital of any possible complications.
4. 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 carrying out 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.
5. 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.
6. I have read and understand the Notice of **Privacy Practices** available on the website and at the practice's office.

Please Print – Patient's Name: _____

Patient's Signature: _____

Date: _____

If Minor:

Please Print – Parent / Responsible Party's Name: _____

Parent / Responsible Party's Signature: _____

Relationship to Patient: _____