Dr.Douaa M. Girgis D.M.D.,PC
Patient Consent

1. I do authorize and give consent to Dr.Girgis and/or 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 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, and or old restorations.

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

6. I understand responsibility for payment of dental services provided in this office for myself or my dependant is mine. Unless other arrangements are made prior to treatment, accounts are to paid on the day services are provided. I have read and I understand Dr. Douaa Girgis's financial policy.

7. I hereby authorize payment of my group insurance benefits, otherwise payable to me, to Dr.Girgis's office. 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.

8. A service charge will be added to the unpaid balance of all accounts not paid within 90 days of treatment date.

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

10. I have had the opportunity to review Dr.Girgis's Notice of Privacy Practices.

11. I understand that if I am unable to keep my appointment, I need to let the office know at least 48 hours in advance. I also understand Dr.Girgis's office reserves the right to assess a $55.00 fee for late cancellations and/or missed appointments.

_____ _____

Print name Date

_____

Signature