Welborne, White & Schmidt

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor and mutually agreed upon by me, to make a thorough diagnosis.

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, fully understand that using anesthetic agents embodies certain risk. I understand that I can ask for a complete recital of any possible complications.

________________________________ ____________________

Signature **Date**

Acknowledgement of Receipt Of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for the above named practice.

_________________________________ ____________________

Signature **Date**

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- Unable to communicate with the patient for the following reason:

____

Prepared By ____

Signature __________________________________ Date _________________