Dr. Robert Batton ***Dr. Justin Harlin***

PATIENT CONSENT TO TREATMENT

Name (Please Print): ____

In reading and signing this form, it is understood that English is the language that I understand and use to communicate. (Initials)_________

1. COMPREHENSIVE EXAMINATION, XRAYS AND PHOTOGRAPHS

I understand that a comprehensive examination and xrays are necessary at my initial visit and periodically thereafter for Dr. Batton/Dr. Harlin to properly and adequately diagnose my dental condition and to make recommendations for needed treatment.

Initials_________

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.

Initials_________

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE AND CONSENT TO THE PROCEDURE(S) AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

Initials_______

I UNDERSTAND THAT THIS FACILITY PROVIDES DENTAL CARE SERVICES WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOR, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DISABILITY, AGE OR MARITAL STATUS AND PROTECTS THE PRIVACY OF EACH OF ITS PATIENTS.

Initials_________

PAYMENT IS DUE AT TIME SERVICES ARE RENDERED

I UNDERSTAND THAT IF I AM DELIQUENT ON MY OBLIGATION TO PAY BATTON AND HARLIN DENTISTRY, THEN I WILL BE RESPONSIBLE FOR ANY LATE FEES, INTEREST CHARGES, COURT COST, ATTORNEY FEES, AND COLLECTION CHARGES SHOULD THE BALANCE NOT BE PAID IN DUE DILIGENCE.

Signature__________________________________Relationship________________Date__________

Doctor____________________________________Witness____________________Date__________

Robert D. Batton, DDS and Justin B. Harlin, DDS
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