Consent

1. The undersigned hereby authorizes Dr. Susan Partovi to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate for Dr. Partovi to make a thorough diagnosis of the patient's dental needs.

2. I also authorize Dr. Susan Partovi to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment.

3. I understand that all responsibility for payment for dental services provided for myself and or my dependents are mine, payble and due at the time services are rendered unless other arrangements have been made. In event that payments are not received by the agreed upon dates, I understand that 1-1/2% finance charge (18% APR) may be added to my account. In cases of a returned check for non sufficient funds I agree to pay the check balance and a $30.00 returned check fee within 15 days of the date on the check. All charges will include but not limited to collection charges, all legal fees and administrative charges.

4. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

5. I understand that my agreement with my dental insurance company is my agreement, and it is my responsibility to make sure that Susan Partovi DDS. PC. is paid in a timely manner, if not by my insurance company then by myself.

6. I hereby authorize Susan Partovi DDS. PC. to affix my name to any claims or documents as related to any and all health benefits due to me and dependents through my employment.

7. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my dental plan prohibiting all or a portion of such charges, to the extent permitted under applicable law, I authorize release of any information relating to the claim.

I have read and understand all of the seven consent items above.

Patient's signature_____Date_____

Parent or Responsible part signature_____
Relationship to patient_____

witness_____ Date_____