CONSENT FOR TREATMENT

1. I authorize Dr. Coulter or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Coulter to make a thorough diagnosis of (name of patient) _____ 's needs.

2. Upon such diagnosis, I authorize Dr. Coulter 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 anesthetic, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, 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. In the event payments are not received by agreed upon date, I understand that a 1 1/2 % late charge (18% APR) may be added to my account.

PATIENT: _____Date: _____

PARENT OR RESPONSBILE PARTY: _____

RELATIONSHIP TO PATIENT: _____

email form to bcoulter@coulterfamilydentistry.com