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Practice number : 094000 0501158|Practice Number: 0216712562

CONSENT

I,patient/parent/guardian\_\_\_\_\_

Of\_\_\_\_\_

Confirm and agree that:

1. The dentist has explained the treatment plan, the risk and alternative treatment to me.
2. I understand that changes in this treatment will be explained to me together with the costs
3. I understand that unforeseen complications may unfortunately arise during treatment and may require different or additional treatment than what was explained to me. I give permission to the dentist or any other specialist I am referred to, to carry out such further or different treatment as may be necessary in the dentists or specialists professional judgment.
4. I have been informed that the fees charged by this practice are NOT based on benefits provided by my medical aid or insurance plan,but are determined by the dentist based on the quality of services, practice costs and standard of service rendered by the practice.The details of the fees and estimates have been fully explained which I accept and undertake to pay on completion of the treatment.I understand the fees quoted to do not include any fees charged by contractors employed by the dentist as part of the treatment.

**5. I understand that there is a deposit required and undertake to pay the deposit before I commence with any of my treatment.**

6. I have been given ample chance to ask any question that I may have regarding treatment and fees charged before treatment begins.
7. I agree that my co-operation is important and shall keep scheduled appointments made for me and agree that I may be charged for appointments not kept which shall be equivalent to the consultation fee.
8. I authorize the dentist to disclose to my medical scheme, funders, employers or any third party as directed by me all or any dental records and information including any treatment plans, prescriptions and other information pertaining to my care by this practice.

I understand that reports may contain personal and confidential information and protected but am required by me to exercise or protect rights and consent to its release.

9. I certify that I read and write the language in which this consent is drafted and fully understand this consent.

**10. I agree to pay all capital and legal expenses on the attorney- and-own client scale of an attorney, in the event of any litigation due to non-settlement.**

**11. PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM BEFORE SIGNING IT.**

DATE:\_\_\_\_\_ PATIENT/PARENT/GUARDIAN\_\_\_\_\_

Signature of person responsible for payment of the accounts of the abovementioned dental practitioner (in the event of the person giving the consent not being liable for payment of the accounts).

DATE:\_\_\_\_\_ NAME\_\_\_\_\_

DATE:\_\_\_\_\_ NAME OF PRACTITIONER\_\_\_\_\_

WITNESS(1):\_\_\_\_\_ WITNESS(2)\_\_\_\_\_