Steven S. Lawson DDS INC
Creating Healthy Smiles

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Consent for Treatment & Authorizations

Name ____ Date of Birth ______________________

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your responsibilities with our practice.

Financial Policy:

Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. **Insurance Plans:** Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage. We collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at the time of service.

Scheduling:

We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment it impacts the overall quality of service and care we are able to provide. We do require a 48-hour notice to reschedule an appointment.

Authorizations:

I have read the above and agree to the financial and scheduling terms listed above. **(initial)____**

I authorize Dr. Lawson's office to discuss my dental treatment and payments with ______________________________________.

I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. **(initial)____**

I authorize the release of information necessary to process my dental benefit claims. **(initial)____**

I hereby give my consent for Dr. Lawson to take photographs of my face, jaw and teeth. I understand that some of these images may be used by labs for fabrication of crowns, veneers, bridges or dentures and these images will become part of my patient record. **(initial)____**

I hereby give my consent to the use of images in professional articles or presentations or to promote the dental practice through printed advertisements, brochures and the practice web site. I understand that my face and name will NOT be used in any outside media. By consenting to the use of the photos and testimonials I do not expect compensation, financial or otherwise, from Dr. Lawson. I hereby release and discharge Steven. S. Lawson DDS, Inc. from all and any claims and demands arising out of or in connection with the use of my name, photograph, personal testimonial or other information provided by me, including any claims for libel and invasion of privacy. **(initial)____**

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. **(initial)____**

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. **(initial)____**

Signature____ Date____________________