Derek J. Chang, DDS, PLLC

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NEW PATIENT CONSENT FOR TREATMENT

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

2. Upon such diagnosis, I authorize the Doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I have the right to ask any and all questions and fully understand my treatment before consenting.

3. I understand that the use of anesthetics, sedatives, and other medication may be 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. I give consent to the Doctor's or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. 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. I realize that the type of insurance plan I have can limit my benefits and I agree to pay the amount my insurance does not cover within 30 days of notice.

6. I understand that there is a $50.00 fee for cancellations made with less than 24 hours notification and no-shows.

_____

Patient (Parent/Guardian) Signature Date

_____

Witness Signature Date