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Consent For Treatment

I, the undersigned patient, hereby authorize Timothy J. Hacker DDS, Neil Johnson, DDS, Danielle Bauman, DDS and their associates to perform the procedure(s) or course(s) of treatment that are attached. I understand my dental condition and have discussed several treatment options with the provider. I have been given a printed copy of the procedure or treatment details and any post-op instructions.

I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize the provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) in the attached treatment plan. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I understand that necessary blood work may be a part of the procedure and give my consent for necessary blood work. I give my consent for the administration of any medication that may be required as a life-saving measure.

I have discussed payment options and agreed upon a payment plan with the insurance company and with the provider.

Signature: _____ Date:_____