



CONSENT

I, patient/parent/guardian

of _____

confirm and agree that:

1. The dentist has explained the treatment plan, the risk and alternative treatment available 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 dentist's or specialist's professional judgement.
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 services rendered by the practice. The details of fees and estimates have been fully explained which I accept and undertake to pay on completion of treatment. I understand the fees quoted do not include any fees charged by contractors employed by the dentist as part of my treatment.
5. I have been given ample chance to ask any question that I may regarding treatment and fees charged before treatment begin.
6. 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.
7. I authorise 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 the reports may contain personal and confidential information and protected but am required by me to exercise or protect my rights and consent to its release.
8. I certify that I read and write the language in which this consent is drafted and fully understand this consent. **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: _____