Hasan Alsawaf, D.D.S., D.M.D.
492 Putnam pike
Greenville,R.I.
(401)949-2590

Family Dental Center of Greenville

Consent for Treatment and Financial Responsibility Contract

1. I hereby authorize Dr H. Alsawaf or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medications as necassary. 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 agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service. In the event payments are not received by agreed upon dates, I understand that a 1 1/2% late charge (18% APR) may be added to my account.

5. Insurance plans are contractual agreements between your employer and insurance carrier. As a provider we must conform to these policies and collect any deductible, coinsurance or co-pays. I agree to pay patient deductible, coinsurance or co-payment as set up by my insurance company at the time of service. I uderstand that it is my responsibility to understand my dental insurance policy.

Patient_____ Date_____ Witness_____

Parent or Responsible Party_____ Relationship to Patient_____