Douglas D. Fogel, D.D.S.
20100 W. 12 Mile Rd., Southfield, MI 48076
T: 248-353-5010
F: 248-353-5005
office@douglasdfogeldds.com

Consent For Treatment:

The undersigned hereby authorizes Douglas D. Fogel, D.D.S. and associates to take x-rays, photographs, study models or any other diagnostic aids deemed appropriate to properly treat the patient's dental needs. I authorize Douglas D. Fogel, D.D.S. and associates to perform any and all forms of treatment, medication and therapy. I understand the use of anesthetic agents embodies a certain risk. I understand that I ask for a complete recital of any possible complications. I authorize Douglas D. Fogel, D.D.S. and associates to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Douglas D. Fogel, D.D.S. I understand my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that such payments are due and payable at the time services are rendered unless a financial agreement has been made in writing. I understand that a finance charge may be added to any overdue balance.

Cancellation policy - a 48 hour notice must be given to cancel or change an appointment. We reserve the right to charge a fee for cancelled or broken appointments with less than a 48 hour notice. After two broken appointments, we reserve the right to require a deposit in order to make another appointment. After a third broken appointment, we reserve the right to dismiss you from the practice.

Patient Signature (Parent of Child/Responsible Party)____________________________ Date____________