JERRY W. REEVES DDS, PA
GENERAL • COSMETIC • IMPLANT
5314-A W. Friendly Ave • Greensboro, NC, 27410 | 336-299-8530

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s 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 medication as 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. By signing this consent form I am authorizing the doctor and designated staff to treat my dependent (if under 18 years old) _____. I understand by leaving him/her in your care you have authority to treat for any emergency protocol. I can be reached at _____.

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. All insurance claims are submitted and filed only as a courtesy by Dr. Jerry Reeves. In the event payments are not received by agreed upon date, I understand that a 1-2% late charge (18% APR) will be added to my account. In the event my account is fumed over to a court case I am responsible for all collection cost, including court cost and attorney fees. I also understand a check of my credit history may be made.

Patient Signature: _____ Date: _____
Witness:_____
Parent/Responsible Party's Signature: _____
Relationship to Patient: _____