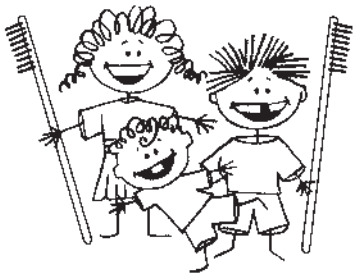

Patient's Name:_____

Consent to proceed:
I authorize Dr Jason J Horgesheimer D.D.S., and/or such associates or assistants as he may designate to perform those procedures as may be necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative including, but not limited to, nitrous oxide, general anesthesia, analgesic, therapeutic, and/or pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause adverse reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me and I have been given the opportunity to ask questions.

SIGNATURE _____ **DATE**_____
(parent or legal guardian)

The responsible party agrees to:
I grant permission to the dentist to perform any necessary dental work needed for this child. Patients with insurance **MUST** pay their **ESTIMATED** portion, including deductible at the time of service. If you need to make payment arrangements, it is required you leave post-dated checks or a credit card on file the day of the appointment. Finance charges will apply to payment arrangements. Please note we submit your insurance as a courtesy to you, it is your responsibility to see the insurance makes prompt payment. Any unpaid insurance over 60 days is due and payable by the responsible party. I also agree to pay my balance within 90 days or the account will be turned over to an outside collection agency. In the event of default, I agree to pay interest of 18% APR, and the cost of any late fee, certified letter fee, rebilling fee, and/or collection fees of up to 30% of my account balance, and the cost of reasonable attorney fees. Credit check will be obtained on accounts that need financial arrangement, that are not paid in full on the date of service.

SIGNATURE _____ **DATE**_____
(parent or legal guardian)