

CONSENT FOR TREATMENT

I, _____, hereby authorize **Ashley Harrison, DDS** to take radiographs, study models, photographs or any other diagnostic aids she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Signature of patient or
authorized responsible party

Relationship

Date