John L Caesar, DDS Salvatore Lotardo, DDS

NESCONSET DENTAL ASSOCIATES

CONSENT FOR TREATMENT

1. I hereby authorize Dr. Sal Lotardo, Dr. John Caesar or designated staff to take any diagnostic aids (photos, x-rays, study models) deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
   (please **print** first and last name)

2. Upon such diagnosis, I authorize recommended treatment mutually agreed upon.

3. **I agree to be responsible for payment of all services rendered on my behalf or my dependents. <u>I understand that payment is due at the time of service unless other arrangements have been made.</u> In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge will be added to my account.**

4. I agree to give Nesconset Dental Associates **24 hours prior notice** of cancellation of a scheduled appointment. Less than 24 hours notice will be considered a missed appointment without adequate notice. If you or one of your dependents fails to give 24 hour notice of cancellation twice in a three month period, Nesconset Dental will charge a $75.00 fee.

5. Acknowledge of receipt of notice of privacy practices.

Patient _____ Date _____ Witness_____