

## **AUTHORITY TO TREAT**

I GIVE Bryan A. Austin, D.D.S. or Clint A. Fulks, D.D.S. and/or their qualified staff the authority to administer dental x-rays, local injections, anesthetics and if requested, nitrous oxide, in the subsequent treatment of my case. If I have a medical condition, such as a heart murmur or an artificial joint that requires pre-medication, or if I am pregnant or think I may be pregnant, **I acknowledge that it is my responsibility to inform and remind the doctor, assistant or hygienist at the beginning of each visit. If I do not understand fully the dental procedure to be performed, it is my responsibility to inform Dr. Austin, Dr. Fulks, or any staff member before proceeding.**

## **PAYMENT AGREEMENT**

I agree to be personally responsible for the payment of all services rendered on my behalf and on the behalf of my family. If I do not understand fully the approximate cost of the dental procedure being performed, it is my responsibility to inform Dr. Austin, or Dr. Fulks, or any staff member, before proceeding. If any check is ever returned, I agree to pay a \$22.50 returned check fee for each occurrence. If I fail to pay my bill in a timely manner, I further agree to pay all necessary costs incurred in the collection of my account.

## **BROKEN APPOINTMENTS**

24 hour notice of cancellation must be given to avoid a broken appointment charge of \$25.00.

## **BILLING CHARGES**

A billing charge will be imposed on the unpaid balance of any procedure which has been posted to your account for 60 days. The minimum monthly charge on a balance is \$0.50.

## **PHOTOGRAPHS**

I give my permission to Bryan A. Austin, D.D.S and Clint A. Fulks, D.D.S. or any representative they may designate, to photograph me for diagnostic purposes and to enhance my medical record. I agree that these photographs will remain the property of Dr. Austin or Dr. Fulks. I further authorize Dr. Austin or Dr. Fulks to use these photographs for teaching purposes, to illustrate scientific papers, books, for use in general lectures, and promotion of this office. It is specifically understood that in any publication or use, I shall not be identified by name.

This office reserves the right to refuse to treat any patient or potential patient. I have read, understand, and agree to the above policies.

\_\_\_\_\_  
Patient Signature (Parent if Minor)

\_\_\_\_\_  
Date