HICKS DENTAL
CONSENT FOR DENTAL TREATMENT

The undersigned hereby authorizes the Doctor to take study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

I understand that my dental insurance is a contract between me and the insurance carrier and **NOT** between the insurance carrier and the doctor, and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental feels incurred. I understand that in the event the insurance check is mailed to me instead of the Doctor, I am to forward that payment to the dental office within, but no later than 10 days. I also acknowledge that cashing insurance checks for dental treatment completed and not paid constitutes fraud and legal actions will be taken to collect and I will be responsible for all legal fees incurred.

_____ _____

DATE SIGNATURE

_____

PRINTED NAME