Bella Smiles Cosmetic and Family Dentistry

54 Commerce Drive, Suite 1
Riverhead, NY 11901
631-591-3243

CONSENT FOR TREATMENT

1. I hereby authorize Dr. Sal Lotardo, 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.

2. I agree to allow Bella Smiles to use my photographs for their portfolio display, case presentation on their website, and to show treatment results to patients.

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

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.33% late charge will be added to my account.

5. I agree to give Bella Smiles 48 hours prior notice of cancellation of any scheduled appointment. Less than 48 hours notice will be considered a missed appointment without adequate notice. If you or one of your dependents fails to give 48 hour notice of cancellation twice in a three month period, Bella Smiles will charge a $75.00 fee.

6. I agree that if I or my dependent misses three appointments without proper notice in a four month period Bella Smiles reserves the right to no longer treat me or my dependant any longer.

Patient _____Date _____