CHRISTOPHER C. KEYS D.D.S.
1505 SOQUEL DR. SUITE 5-B
SANTA CRUZ, CA 95065

CONSENT FOR TREATMENT

1. **I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and Other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name Of patient)____________________________dental needs.**

2. **Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually Agreed upon by me and to employ such assistance as required to provide proper care.**

3. **I agree to the use of anesthetics, sedatives and other medication as necessary. I fully Understand that using anesthetic agents embodies certain risks. I understand that I can ask For a complete recital of any possible complications.**

4. **Electronic health records that are individually identifiable as mine for the purpose of carrying Out my treatment payment, and health care operations. I understand that only the minimum Amount of information necessary to provide quality care will be used or disclosed, and that a Notice fully outlining the protection of my personal health information is fully available.**

5. **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 1-1/2% late charge of 18% APR may be added to my account.**

Patients Signature____Date__________________

Parent/Responsible Party Signature___________________________Date__________________