R. Thomas Bayley, III, DMD, PC
Robert T. Bayley, IV, DMD
Akil A. Patel, DDS
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(p) 610-692-7868
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FINANCIAL CONSENT

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

2. I also authorize the doctor to perform all mutually recommended treatment agreed upon by me and to use the appropriate medications and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. I also authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

3. I understand that all responsibility for payment for dental services provided in the office for myself or my dependents is mine, due and payable at the time of service unless other arrangements have been made in advance. If payments are not received by the agreed upon dates, I understand that 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.

4. I understand that credit bureau reports may be obtained.

5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____

Parent or Responsible Party _____

Relationship to Patient _____