San Ramon Valley Dental
Dr. Paul Fillet

Practice Consent Form

I hereby authorize Dr. Fillet or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs for proper dental care.

Upon such diagnosis, I authorize Dr. Fillet to perform all recommended treatment mutually agreed upon by me and to employ such assistance to provide care.

I agree to the use of anesthetics 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.

I request and authorize Dr. Fillet to do whatever he deems advisable if any unforeseen condition should arise in the course of procedures I may need.

I authorize release of any information concerning my health care, advice, and treatment to another dentist.

I understand that my dental plan or payer of my dental benfits may pay less than the actual bill or services; I understand that I am financially responsible in full for all services provided. I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care plan.

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administration claims for insurance benefits.

I hereby authorize payment of dental plan benefits directly to Dr. Fillet, otherwise payable to me.

I understand that any appointments outside of the regular office hours are subject to additional fees.

I agree to be responsible for payment, in full, of services rendered on my behalf. I understand that payment is due at the time of services are provided unless other arrangements have been made in writing. In the event payments are not received by the time of service, I understand that a finance charge of 23% APR or 1.92% per month will be added to by account on my balance.

I have read and understand the Practice Consent Form.

Patient Signature (Parent or Guardian if minor)	Name of Patient	Date

Signature of Witness

Paul G. Fillet, DMD, Inc.
2420 San Ramon Valley Blvd.
San Ramon, Ca 94583
Ph (925) 820-6541 Fax (925) 820-1618
drfillet@yahoo.com