The undersigned hereby authorizes Atchison Dental Associates to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Atchison Dental Associates to perform any and all forms of treatment, medication and therapy that may be indicated, and that the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made with the office. I also assign all insurance benefits to Atchison Dental Associates, and understand that my dental insurance is a contract between me and the insurance carrier. I understand that I will be charged for all dental treatment and that I am responsible for all fees incurred. I understand any payments received by Atchison Dental Associates from my insurance coverage will be credited to my account or refunded to me if I have paid the fees incurred. I have had the opportunity to read and consider the contents of the consent form and the Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to Atchison Dental Associated to use and disclose my protected health information to carry out treatment, payment activities, and health care operations.

Signature_____