Dr. Barry Bessler, D.M.D
CONSENT FOR TREATMENT

I, the undersigned, hereby authorize my doctor(s) to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my determined needs. I understand and permission for Dr. Barry Bessler D.M.D, to use those materials for dental purposes in lectures, seminars, and shared with other healthcare providers, without my name being revealed. I understand that x-rays are required on a yearly basis for accurate diagnosis. I also authorize the Doctor to perform necessary treatment that is indicated. I also understand that the use of anesthetic agents embodies a certain risk and I acknowledge that I have provided a thorough and honest report of my medical and dental history. I understand that any treatment plans presented, along with fees outlined, could change depending on the time elapsed since the initial examination and extent of dental pathology. Occasionally once the treatment plan has been started, complications may arise that may dictate additional procedures or treatment. The Doctors or their staff members will always advise me of any changes. I understand that there is no guarantee to the outcome of any services performed.

Print name: ____

Signature: ____

Date: __________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Circle:

Individual refused to sign!
Communication Barriers prohibited obtaining the acknowledgement!
An Emergency situation prevented us from obtaining acknowledgement!
Other (please specify):________________________________

Patients name: ____ Date: ______________