Michael Ruhkala, D.D.S.
PO Box 640, St. Ignatius, MT 59865
406-745-3951

Consent for Treatment

I hereby authorize doctor or designated staff to take x-rays, study model, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed to by me and to employ such assistance as required to provide proper 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 complication.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written, or 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 available.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand 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 ½% late charge (18% APR) may be added to my account.

_____ _____

Patient/Parent or Responsible Party's Signature *Date*

Assignment of Insurance Benefits

I agree to be responsible for all charges for dental services and a material not paid by my dental benefits plan, unless prohibited by law. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

_____ _____

Patient/Guardian Signature *Date*

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to *Mission Valley Dental Clinic.*

_____ _____

Insurance Subscriber Signature *Date*

Financial Options

All treatment is to be paid at the time of service, ***unless*** insurance is involved and therefore your ESTIMATED CO-PAY is due at the time of service. We Accept:

Cash *Check* *Credit/Debit Card* *Payment Plans (upon approval)*