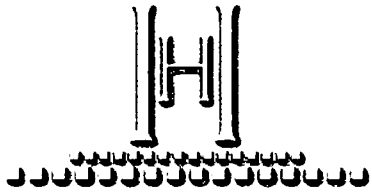

THOMAS J. HART, JR. D.D.S.
D. CASEY HART. D.D.S.
GENERAL DENTISTRY

Consent For Treatment

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

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

3. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete explanation of any possible complications.

4. 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.

5. I authorize the use of my signature on all insurance submissions giving permission to the doctor to release any information necessary to process claims or predeterminations of benefits. I also authorize my insurance company to assign benefits payable to the doctor whenever possible.

6. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. If payments are not received by agreed upon dates, I understand that a 1 1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

_____ _____ _____
Patient's Signature Date Witness

_____ _____
Parent/Responsible Party's Signature Relationship To Patient