Ricardo A. Perez, D.D.S, P.C

Patient Consent

Patients name: ____ Date of birth: _______/_______/________

Treatment Authorization

I hereby give authorization as parent or legal guardian to Ricardo A. Perez, D.D.S, P.C., for the completion of all agreed upon dental services for my child.

Initial: _________

Electronic E-Mail Consent

I acknowledge Metropolitan Pediatric Dentistry may send information regarding my child's treatment, consultation notes, and radiographic images, via standard (unencrypted) Electronic Mail (E-Mail) to other doctors involved in my child's care, and or to myself, upon request.

Initial: _________

Privacy Practices Acknowledgement/HIPPA

I have received and reviewed a copy of the dental practice's privacy, security and breach notification policies and procedures. I understand that should I have any questions regarding these policies and procedures, I have the right to ask the practice's Privacy Official.

Initial: _________

Financial Agreement

I acknowledge that payment is due at the time of treatment unless other arrangements are made. I accept full financial responsibility for all charges for services or items provided to my child/children.

Initial: _________

Signature Relationship Date