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

2. Upon such diagnosis, I authorize Dr. J. Silberman or Dr. J. Marsek 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 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 possible complications.

4. There is a fee of $65 per appointment hour for any missed appointment and/or cancelled appointment with less than 48 hours notice.

5. 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 in advance.

Patient Signature _____Date_____

Responsible Party _____

Relationship to Patient _____