



**Phillip D. Katz DDS**

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**It is our purpose at this office to provide care to our patients as if they were part of our own family. Family is a very meaningful word. It is family that you are truly eager to see. It is family that you really desire not to keep waiting. It is a family member that you want to help get exactly what they want. It is family that deserves only the best**



I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in any medical status. I authorize the dental staff to perform any necessary dental services. Such as x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. I also authorize the doctor (and his/her employees for assistance when applicable) to perform any and all forms of treatment, medication and therapy with my informed consent in connection with my diagnosis and treatment plan. Even though I may have dental insurance coverage, I understand payment for services rendered is my responsibility. It is my understanding that payment is due at the time of service, unless other financial arrangements have been made.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Financial Coordinator \_\_\_\_\_ Date \_\_\_\_\_

# INFORMED CONSENT