NOLL DENTISTRY, LLC
3309 Dixie Hwy.
ERLANGER, KY 41018
859-727-1919

Treatment Authorization

I, _____, hereby authorize Dr. Noll and her staff to perform upon me (or the named patient) the necessary dental procedure(s) and will also inform me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. The attendant risks of no treatment will be discussed. I will be given an opportunity to ask questions, and all my questions will be answered fully and satisfactorily. I acknowledge that no guarantee or assurances will be made to be concerning the results intended from the procedures(s).

I understand that during the course of the procedure(s), unforeseen conditions may arise, which necessitate procedures different from those contemplated. I, therefore, consent to the performance of additional procedures, which the above may consider necessary.

I understand that I am responsible for all fees regardless of insurance coverage, if it applies.

I confirm that I have read and fully understand the above.

I hereby consent to dental treatment.

_____ _____

Signature of Patient, or Personal Representative **Date**