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**Consent for Treatment**

I hereby authorize Dr. Norris, Dr. Ozer or their designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis of (name of patient)\_\_\_\_\_’s dental needs.

Upon such diagnosis, I authorize Dr. Norris and/or Dr. Ozer to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

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.

I give consent to Dr. Norris’, Dr. Ozer’s or their 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 upon request.

I agree to be responsible for payment of all services rendered on my behalf or that of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

I understand that a \$50 cancellation fee will be applied to my account for any hygiene appointments that are missed or canceled with less than 24 hours notice. A minimum cancellation fee of \$200 will be applied for diagnostic, restorative or cosmetic appointments that are missed or canceled with less than 24 hours notice.

Patient’s Signature \_\_\_\_\_ Please Print Name \_\_\_\_\_

Parent/Responsible Party Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

**Acknowledgement of Receipt of Notice of Privacy Practices**

I \_\_\_\_\_ have received a copy of this office’s Notice of Privacy Practices.

Patient’s Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

\_\_\_\_\_  
For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because \_\_\_\_\_.