CONSENT FOR TREATMENT

		ed appropriate by doctor to make	
		rize doctor to perform all recom and to employ such assistance as	
	 I agree to the use of anesthetic understand that using anesthetic can ask for a complete recital or 	tic agents embodies certain risks.	요즘이 시간이 사랑 보면 없었다면 하다는 것 같아?
	purpose of carrying out my treat understand that only the minimu	rds that are individually identifiable ment, payment and health care or ment amount of information necessared that a notice fully outlining the p	e as mine for the perations. I by to provide quality
	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 the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.		
Patient's Sign	nature	Date	Witness

Parent/Responsible Party's Signature _

_ Relationship to Patient _