**SAMPLE FINANCIAL CONSENT FORM**

Thank you for consulting with Dr *<<doctor’s name>>* about your proposed <<*set our details of treatment/procedure e.g. Root Canal Therapy etc.*>> (**Procedure**).

This form sets out the costs of the Procedure in order to assist you in making an informed decision about it. By signing this form, you agree to the costs of the Procedure as set out below.

This form is to be read together with any other agreements that you may have entered into regarding the costs of the Procedure.

***Cost of Procedure***

The cost of the Procedure will be as follows:

*<<Insert estimate or quote (as well as GST component)>>*;

Payment for the Procedure is to be made as follows:

*<<Specify whether payment will be required before/at the time of/after the Procedure and how soon before or after the Procedure full payment is required. If it can be paid in instalments, set out the instalment amounts, when each instalment is due and whether full payment will be required should any instalment not be made>>.*

***Additional Costs***

The above *<<quote/estimate>>* is based on the information currently known to Dr *<<doctor’s name>>*.

If something unexpected arises during the Procedure, or if it has unexpected effects, this may result in further procedures, treatment or investigation which will incur further costs at the rates usually charged by Dr *<<doctor’s name>>*.

***Withholding of Further Treatment*** *<< Delete this if it is not applicable>>*

If you fail to pay the costs of the Procedure or any part of those costs, Dr *<<doctor’s name>>* may, by prior written notice to you, to the fullest extent permitted by law, not complete the Procedure and/or may withhold any further treatment in relation to the Procedure. In that event, you indemnify Dr *<<doctor’s name>>* for any loss or damage that you may sustain because of this.

***Agreement***

I, the undersigned, agree to the above terms.

Date of signature:

|  |  |  |
| --- | --- | --- |
| Patient name |  | Patient signature |

|  |  |  |
| --- | --- | --- |
| Name of parent/guardian (if applicable) |  | Signature of parent/guardian (if applicable) |

|  |  |  |
| --- | --- | --- |
| Doctor’s name |  | Doctor’s signature |