PETER A. MCINTYRE D.D.S., P.C.

Consent for Treatment

Facility:_____

_____has been seen by, or is being scheduled with Dr. McIntyre to determine dental needs. Please review any proposed treatment plan. If this is to be an inital visit, fees begin at $60.00. Please understand this is not to be considered exact or all-inclusive, as dental needs may change as conditions progress, or unknown circumstances arise during the course of treatment.

- This person has dental insurance. Required information will be provided.-There may be som associated out of pocket expense.
- Evercare Insurance
- This person has PETI benefits
- This person is private pay. If not POA addrss, please provide here:

I have reivewed the proposed treatment plan and I authorize Dr. McIntyre to begin treatment. I understand this is only an estimate and the patient may be ultimately responsible for all or part of the bill, should the patient become ineligible for PETI benefits, if applicable to this patient's method of funding.

Please call our office if you have questions about your financial responsiblity.

_____I *DO* want treatment;_____I *DO NOT* want treatment

Signature:_____**Date:**_____

Appointment
Needed:_____

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