I, ______________________________, being the parent, guardian, or other person

entitled to legal custody of ____________________________, a minor child, do hereby authorize and consent to any x-ray, examination, anesthetic, or dental treatment to be rendered to said minor child under the general or direct supervision of Dr. Ryan LeMert, D.M.D. may deem necessary.

This authorization will remain in effect until _____________________________.

Signed:_________________________

Dated:__________________________

All dental procedures will be guaranteed for the next two years, excluding additional tooth decay and trauma, providing routine exams and dental care services that are recommended by Dr. LeMert are followed within this time period.

Signed: _________________________________ Dated: ____________________

Failed appointments and short notice cancellations for all patients, including those with Medicaid (DSHS), are subject to a $75.00 charge per appointment. Failed appointments delay the treatment for fellow patients.

Signed: _________________________________ Dated: ____________________