

**Matthew McRae, Jr., D.M.D and Associates**  
**995 Baxter Street**  
**Athens, GA 30606**

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**Consent for Services**

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon 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 agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payment is due at the time of service unless other arrangements have been made.**

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Signature of patient/parent/Guardian      Date      Relationship to Patient

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**Acknowledgement of Receipt of Privacy Practices and HIPPA  
Statement**

I have read a copy of the Notice of Privacy Practices and a copy of the HIPPA statement for the above named practice. (This form is located in the magazine rack in the waiting area and in the glass case on the wall in the waiting area.)

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Signature of patient/parent/guardian      Date      Relationship to Patient

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**Medicaid / Insurance Authorization**

I authorize release of information to all my insurance carriers.

I authorize payment directly to my doctor.

**I agree that it is my responsibility to understand my insurance benefits. I understand that the office of Dr. Matthew McRae, Jr., DMD, PC and Associates may or may not be participating with my insurance plan, and I will be responsible for any balance left unpaid by my insurance company.**

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Signature of patient/parent/guardian      Date      Relationship to patient