

**John J. Ahern, D.D.S., P.C.**  
**RidgeGate Dental**

10450 East Park Meadows Drive, #301 Lone Tree, CO 80124

**Informed Consent**

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand the use of anesthetic and antibiotic agents embody a certain risk. I also understand that dentistry is not an exact science, and therefore, guaranteed predictable results are not always possible.

I understand that my dental insurance is a contract between the insurance carrier and me, and not between the insurance carrier and the Doctor. I acknowledge that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered. I understand that an annual percentage interest rate of 18% will be charged on all unpaid balances past 30 days. I understand that unpaid insurance claims are my responsibility. I also understand that no guarantees are made by this dental office as to insurance payments or responsibilities. I agree to pay any attorney's fees, collection fees, and/or court costs that may be incurred to satisfy this obligation. I further understand that a late charge may be added to any overdue balance.

**Patient Signature (Parent of a child):** \_\_\_\_\_

Date: \_\_\_\_\_

**Doctor Signature:** \_\_\_\_\_

Date: \_\_\_\_\_