In case the patient insisted on changing the treatment plan in conflict with the dentist's advice, he / she or his / her representative or the person responsible for him / her has to sign a pledge that exempts Dentistree Dental Clinic, and its Dentists, in full from of any liability whatsoever, whether financial, medical, legal or moral.

The patient's absence on the dates and timings set for him / her or lack of commitment to the doctor's instructions could lead to complications that would change the treatment plan, or lead to its failure, and in such case, he/she alone would be responsible to pay the cost of the original treatment plan already agreed upon in addition to the additional cost resulting from modifying the treatment plan. The patient in this case is responsible about the results whatsoever and should fully exempt Dentistree Dental Clinic and its doctors from any liability whether financial, medical, legal or moral.

The cost of all stages of treatment must be paid in full in advance and is non- refundable at any stage of then treatment, even if the patient did not complete the treatment for any reason whatsoever. Signing this paper by the patient or any person who is responsible for him/her or represents him/her means that:
He/she has read the paper and understood its contents, and has questioned in a full and satisfactory manner about everything related to the treatment from the doctors of the center and any other party he wants to consult, and that he has approved what was explained to them and requested the physicians of Dentistree Dental Clinic to begin the treatment and gave them the authority to do whatever they consider is appropriate for his/her case, and pledged to follow their instructions, attend all the treatment sessions on time and pay the treatment cost in full.

I have read all what is mentioned above and I will sign below in agreement on it.

، البدء في ا لعلاج و فوضهم بعمل ما يرونه مناسب لعلاجه وتعهد
و مواعيد العلاج و بدفع كامل تكلفة العلاج.

، عليه أوقع توقيع المريض/ المريضة أو من يمثله:

Sign here, only if all of your questions have been answered to your satisfaction

Maryam Adil Ahammad

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Patient's name **Signature of Patient Legally authorized Representative** **Da**

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Witness Signature

Da

Dr. Pearl Pinto

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Dr. Pearl Pinto
General Dentist
DHA-04205785-003
DENTISTREE DENTAL CLINIC