

Name of Patient _____

Consent For Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agent embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangement have been made. In the event payments are not received within 30 days treatment is completed, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

Patient Consent and Acknowledgement for use and Disclosure of Health Information and for Receipt of Notice of Privacy Practices

I agree to allow this health care office to use or disclose the protected health care information of the above patients to carry out treatment, payment, or health care operations.

I have been informed of the existence of the Notice of Privacy Practices. The Notice is a more complete description of the uses and disclosures of the protected health information that may be made, and of my rights with respect to protected health information.

- I understand that I have the right to review the Notice before signing this consent.
- I understand that I have the right of request a copy of the Notice.
- I understand that the terms of the Notice may change, and that I have the right to request a revised copy of the Notice.

I understand that I have the right to request a restriction on how protected health information is used or disclosed to carry out treatment, payment, and health care operations. This request for restriction must be in writing. If the health care provider agrees to the restriction, the restriction is binding. However, the health care provider is not required to agree to a requested restriction.

I understand that I have the right to revoke this consent at any time. This revocation must be in writing. Please understand that revocation of this consent will not affect any action we took in reliance on the consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Release: I hereby release the use of my testimonial and/or electronic and/or still photography, for the purposes of any or all marketing/educational materials for Dr. F.H. Collins III, and/or its assigns without compensation.

Patient Signature _____ Date _____

Parent/Responsible Party's Signature _____

Relationship to Patient _____ Witness _____