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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY ACT.

PLEASE PRINT NAME_____

SIGNATURE _____ DATE_____

FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

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 (name of patient)_____'s 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 any any 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.
4) I give consent to the doctor's 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.

PATIENT NAME_____ DATE_____

PARENT/RESPONSIBLE PARTY'S SIGNATURE _____

RELATIONSHIP TO PATIENT_____