HOWARD Family Dental®

# General Treatment Consent - Adult

Patient Name _____

I give my consent to receive dental treatment, education, and other dental-related services. I authorize the administration of anesthetics, as may be considered necessary, and the use of oral x-rays during the treatment. I will receive instructions about the benefits and risks of the necessary procedures, and I will have the opportunity to discuss and approve the recommended treatment. I acknowledge that I have not received guarantees, warranties, or representations concerning the results of the treatment or procedures.

I accept the responsibility to follow oral hygiene and post-op instructions, come to all the appointments on the proper day and time, provide accurate and updated health information, and alert this office of anything that may adversely affect the treatment.

By consenting to treatment, I understand there is risk of infectious diseases. Despite taking reasonable precautions to ensure your health and safety, it is impossible to eliminate all risk of contracting an infectious disease while receiving dental care.

I have the right to withdraw this consent at any time. I will still be responsible for the unpaid balance and for any complication arising from the treatment interruption.

Signature_____Date _____

I refuse or withdraw my consent for treatment

Signature_____Date _____

## Summary of Notice of Privacy Practices

*Our Privacy Practices comply with Omnibus 2013*

Howard Family Dental keeps information of all your dental visits. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with your information upon request. You can also find the Notice on our website. This notice is a detailed explanation on how we may use your protected health information and your rights to inspect and amend your information. Law requires us, and by our code of ethics, to keep your information private, and to follow the practices outlined in this Notice. Our Privacy Practices comply with Omnibus 2013 and are updated effective 09/23/2013.

I have had full opportunity to read and consider the contents of this office's Notice of Privacy Practices. I understand I am giving my permission to use and disclose my protected health information to use in treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke or modify this permission.

Print Name: _____ Signature _____ Date _____

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**For Office Use Only**

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but could not obtain acknowledgment because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (Please Specify)

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