

Consent for Dental Treatment

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. Upon such diagnosis, I authorize the 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 agents embodies certain *risks*. I understand that I can ask for a complete recital of any possible complications.
4. I hereby give lifetime authorization for payment of insurance benefits to be made directly to ATHENS DENTAL SERVICES for services rendered. I hereby authorize ATHENS DENTAL SERVICES to release all information necessary to secure payment of benefits.
5. ***I understand I am financially responsible for all charges, whether or not covered by insurance. Payment is due at the time of service*** unless other arrangements have been made prior to this appointment. In the event of default, I understand that service charges and court fees may apply and a check of my credit history may be made.

Patient's or Responsible Party Signature _____

Relationship to Patient _____

Date signed _____

Acknowledgement of Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES: You have the right to read our NOTICE OF PRIVACY PRACTICES before you decide whether to sign this Consent. Our NOTICE provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our NOTICE may be viewed at the front desk. We encourage you to read it carefully and completely before signing this consent.

I hereby acknowledge that I have had full opportunity to read and consider the contents of this office's NOTICE OF PRIVACY PRACTICES. I understand that, by signing this Consent form, I am giving my consent to ATHENS DENTAL SERVICES use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Patient's or Responsible Party Name (please print) _____

Patient's or Responsible Party Signature _____

Relationship to Patient _____

Date signed _____

_____ Patient refused to sign.
Athens Dental Services employee signature _____