Acknowledgment & Consent

Consent for Treatment

I give my consent for examination and treatment necessary by or under the practicing doctor/team member on site at Smile of Aurora. This includes radiographs as necessary, use of local anesthetic, nitrous oxide analgesia, and the use of appropriate medications and materials for my dental treatment. I have read the information and verbally asked any questions. By my signature below I authorize the treatment necessary for my dental care.

Initials: _____

Insurance Authorization

I agree to be responsible for all charges for dental services not paid by my dental plan, unless the treating dentist or dental practice has a contractual agreement with my plan to write off a portion of the charges. I authorize the disclosure of my protected health information for treatment, payment and healthcare operations and the electronic, paper, fax or verbal transmission of protected health information to a clearinghouse, as well as, to and from my insurance company(ies), its employees and authorized representatives. I authorize the disclosure of my protected health information to my employer and my employer's personnel office for processing my insurance claims or verification of coverage relating to my dental treatment and collecting unpaid balances for services rendered

Initials: _____

Notice of Privacy Practices

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Initials: _____

Please name two (2) people we may contact in case of emergency, to confirm appointments, share other information with, or may make account payments:

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Patient Name: _____ Date of Birth: _____

Signature of Patient or Responsible Party:_____ Date _____