KENT CITY DENTAL CENTER
GENERAL CONSENT FORM

Consent to Treatment and financial Responsibility:

I hereby authorize and request the performance of dental services and procedures Dr. Watkins may deem necessary for treatment. I understand that Dr. Watkins and the assistants he may designate for treatment, will use clinical and patient management techniques that are reasonable, necessary and advisable by Dr. Watkins. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks and that I fully understand the same. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen may occasionally produce nausea and vomiting. I have been informed of the above potential risks and complications.

I authorize the doctor and his auxiliaries to use radiographs, models, photographs, etc., for the purpose of treatment planning and communication with other dental or medical professionals or my insurance company (ies) if such material is required or requested.

I understand that any treatment plans presented, along with the fees outlined, could change depending on the time lapsed since the initial examination and extent of dental pathology. Occasionally, once the treatment plan has been started, complications may arise which dictate additional procedures or treatment. Doctor or his staff will always advise me of any changes.

In the event that Doctor or a staff member is exposed to my blood or other bodily fluid, I agree to have my blood drawn and tested for Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), or Human Immunodeficiency Virus (HIV). This testing would be done in a confidential manner and would be available only to the person who was exposed, and that person would be advised of my rights regarding protected health information.

I agree to be RESPONSIBLE FOR FULL PAYMENT of all charges for services performed on me, on the day of service. If for any reason the insurance company does not pay their estimated portion, I will be responsible for this account. I agree that it is my responsibility to know what my insurance benefits are, if I have and what my deductible is. I understand that Kent City Dental Center will bill my insurance company strictly as a COURTESY to me, and in no way takes responsibility for their denial or payment. In the event my account is placed with a third party Collection agency or an attorney, I will be assessed any fees relating to this action.

Consent for use and disclosure of health information:

I understand that by signing this consent form, I am giving my consent for your use and disclosure of by protected health information as described on the Notice of Privacy Practices to carry out treatment, payment activities, and health care operations.

DATE: _____

PATIENT
SIGNATURE:_____

If patient is a minor, or if consent is signed by a personal representative on behalf of the patient, please complete the following:

PARTENT/GUARDIAN SIGNATURE:_____

PRINTED NAME OF ABOVE:_____

RELATIONSHIP TO PATIENT:_____DATE:_____