Holland *family* Dentistry
GENERAL CONSENT FORM

SECTION A: PATIENT INFORMATION

Patient Name:_____Date of Birth:_____

SECTION B: CONSENT TO TREATMENT

I do hereby authorize and request the performance of dental services for me and the use of whatever procedures Holland Family Dentistry may deem necessary for treatment. I understand that Holland Family Dentistry will use clinical and patient management techniques that are reasonable, necessary and advisable. I also authorize the administration of anesthetics or analgesics, which may be deemed advisable to Holland Family Dentistry.

I understand that any treatment plans presented, along with the fees outlined, could change depending on the time elapsed 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. Holland Family Dentistry will always advise me of any changes.

In the event that a Holland Family Dentistry staff member is exposed to my blood or other bodily fluids, I agree to have my blood drawn and tested for Hepatitis B virus (HBV), Hepatitis C virus (HCV), and the human immunodeficiency virus (HIV). I understand that this testing would be done in a confidential manner, and would be made available only to the person who was exposed, and that person would be advised of my rights regarding protected health information.

SECTION C: FINANCIAL RESPONSIBILITY

I agree to be responsible for full payment of all charges for dental services performed on me. If for any reason the insurance company does not pay their estimated portion, I agree that I will be responsible for the account. In the event that my account is placed with a third party collection agency or attorney, I will be assessed any fees relating to this action.

SECTION D: CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have been offered a copy of and have had full opportunity to read and consider your Notice of Privacy Practices. This 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.

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

SECTION E: CONSENT FOR USE OF PHOTS

I hereby authorize Holland Family Dentistry, hereafter referred to as Holland Family Dentistry to publish photographs taken of me on and my name and likeness, for use in Holland Family Dentistry print, online and video-based marketing materials, as well as other Company publications.

I hereby release and hold harmless Holland Family Dentistry from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Company publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release Holland Family Dentistry, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

_____Yes, I consent for my photographs to be used _____ No, I do not consent for my photographs to be used

Signature of Patient/ Parent/Guardian:_____**Date:** _____

Printed name of Parent, Guardian or Personal Representative: _____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT