

Dr. Scott D. Davis DDS PS
PREMIERE DENTAL OF SPOKANE
123 W. Francis Ave., Suite 103, Spokane, WA 99205
509-489-8863

CONSENT FORM

- The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
- I also authorized doctor to perform all recommended treatments mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with
(name of patient): _____ .
- I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
- I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time of service are rendered unless other arrangements have been made.
- Lastly, I understand that where appropriate, credit bureau reports may be obtained.

Patient Signature _____ Date _____

Responsible Party _____

**ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES**

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature:

Date:

Relationship to Patient:

Dependent family members also covered by this acknowledgement:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

The Patient refused to sign - Communication barriers - Emergency situation - Other