PRISTINE PERIODONTICS AND IMPLANTS | A. SAYED, DDS, MS

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 Dr. Sayed may deem necessary for treatment. I understand that Pristine Periodontics and Implants 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 Pristine Periodontics and Implants.

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. Pristine Periodontics and Implants will always advise me of any changes.

In the event that any team member at Pristine Periodontics and Implants 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 my account and the remaining balance. 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 E: 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 treatment, payment activities and healthcare operations, of the uses and disclosures that 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.

SIGNATURE

Patient Signature: _____**Date**: _____

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

Signature of Parent, Guardian or Personal Representative: _____

Printed name of Parent, Guardian or Personal Representative: _____

Relationship to Patient: _____ Date: _____

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