FRICK & JONES, P.A.
practice limited to periodontics

CONSENT FOR SERVICES

I hereby authorize doctor (or designated staff) to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Frick & Jones, PA. to make a thorough diagnosis of my/dependent's dental needs. I also consent to the use of x-rays and/or intraoral photos taken of me for staff education, patient education, and clinical studies by Frick & Jones, PA. NO IDENTIFYING INFORMATION WILL BE USED.

I understand that the use of anesthetics and sedatives may be necessary and with their use embodies certain risks. I am aware that by my request, I am entitled to a complete recital of potential complications.

I understand that as a condition of my treatment by this office, financial arrangements must be made in advance. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services.

NOTICE OF PRIVACY PRACTICES

You have the right to read the Notice of Privacy Practice (HIPPA) which provides a description of office treatment, payment activities and healthcare operations, of the uses and disclosures we may make to your protected health information, and other important matters about your protected health information. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

PATIENT RIGHTS

You have the right to look at or get copies of your health information, with limited exceptions. I grant my permission to you or your assignee to telephone me at home, by cell phone or at my work to discuss matters related to this form and all aspects of my treatment and financial planning. I have read the above conditions of treatment and payment and agree to their content.

Patient Signature: _____

Responsible Party Signature_____

Relationship to Patient: _____

Date_____