NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I acknowledge that Beers Family Dental has offered me a copy of this document. I understand this form means only that I have received the Notice of Privacy Practices and in no way affects the care I receive at Beers Family Dental. This is in accordance with the federal government HIPPA rules.

CONSENT FOR TREATMENT & AUTHORIZATION AND RELEASE OF INFORMATION

Consent for Treatment: I do hereby voluntarily consent to Beers Family Dental for my dental care and treatment. I understand that this consent will cover all aspects of routine dental care and the risks associated with such care including: x-rays, photographic records, local anesthetics, sedative drugs, restorative dentistry, cleanings, fillings, orthodontic care, fitting of dentures, crowns and bridges and minor surgical procedures including gum surgery, biopsies. Although this entity has agreed to provide me with the best care possible, I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments and examinations by this facility. This consent will remain in effect for the present visit as well as for subsequent visits during the course of treatment.

Authorization and Release: I certify that I have read and understand the information and have answered all questions truthfully and to the best of my knowledge. I authorize the dentist to release any information including the dental care to third party payers and/or health practitioners. Including such photographing, videotaping, or other observation of the operation(s)/procedure(s) as may be purposing for the advance of dental knowledge and/or education, with the understanding that my/the patient's identity will remain anonymous.

I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. **YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

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Signature of Patient or Responsible Party **Date**