SUTTON DENTAL PATIENT CONSENT & HIPAA SIGNATURE

I do authorize and give consent to Sutton Dental, the Dentist and his/her staff to administer treatment, including but not limited to local anesthesia and other such treatments, which in their judgment, may be necessary for the prudent exercise of medical or dental care. I understand that the use of medications, anesthetics and some procedures embody a certain risk.

I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.

I understand that during the procedure(s) unforeseen conditions may arise that necessitate different procedures from those originally planned. I consent to the performance of additional procedures that are deemed necessary in the professional judgment of the dentist. I understand that payment for these additional procedures is my responsibility.

I consent to the disposal of any tissues or body parts that may be removed.

The attached medical and dental history was completed fully and accurately to the best of my knowledge.

I understand responsibility for payment of dental services provided by this office for myself or my dependent is mine. Accounts are to be paid on the date service is rendered. I have read and I understand Sutton Dental financial policy.

I hereby authorize payment of my group insurance benefits, otherwise payable to me to Sutton Dental. In the event of legal action of this account, I agree to pay any and all costs, collection and attorney fees. I have reviewed the treatment plan and authorize the release of any information relative to insurance claims.

I grant permission to you or your assignees to telephone me at home or at my work to discuss matters related to my treatment or account.

I have had the opportunity to review Sutton Dental’s Notice of Privacy Practices.

I understand that if I am unable to keep my scheduled appointment I need to give Sutton Dental at least a 48 hour notice.

HIPAA_____Date_____

Consent_____Date_____