Patient Acknowledgement

Receipt of

Dental Material Fact Sheet & HIPPA Notice of Privacy Practices

I, _____, acknowledge receipt of Information on Dental Materials Act Sheet & HIPPA of Privacy Practices from the office of Byron L. Carr, DMD FAGD

_____ _____

Patient Signature Date

CONSENT FOR TREATMENT

I hereby authorize Dr. Carr or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by Dr. Carr to make a thorough diagnosis of (name of patient) _____'s dental needs.

Upon such diagnosis, I authorize Dr. Carr to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to Dr. Carr or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care options. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that 1 – 1 ½% late charge (18% APR) may be added to my account and I also understand a check of my credit may be made.

_____ _____ _____

Patient's Signature Date Witness

_____ _____ _____

Parent/Responsible Party Date Relationship to Patient