GREAT POND DENTAL GENERAL CONSENT FOR TREATMENT

I, the undersigned, hereby authorize my doctor(s) to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my determined needs. I understand and give permission for Great Pond Dental to use these materials for dental purposes in lectures, seminars, and photo albums. I understand that x-rays are required on a yearly basis for accurate diagnoses. I also authorize the doctors to perform necessary treatment that is indicated. I understand that the use of anesthetic agents embodies a certain risk and I acknowledge that I have provided a thorough and honest report of my medical and dental history.

I understand that any treatment plans presented, along with 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 that dictate additional procedures or treatment. The doctors or their staff members will always advise me of any changes. I understand that there is no guarantee to the outcome of any services performed.

_____

Please Print Name

_____

Signature

_____

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, have received/seen a copy of this office's Notice of Privacy Practices.

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please specify) _____

_____