OFFICE NOTICE/POLICY

TREATMENT

I am aware that treatment will be rendered by licensed Dentists and/or Hygienists.
I understand that my treatment will be provided according to the availability of the practitioner.
I will make known any diseases, allergies, or unusual reactions to drugs or medicines that have occurred to me in the past.
If my health or medications change, I will inform the Doctor/Hygienist at my next appointment without fail.
As the parent, I will be responsible for signing treatment consent forms ***prior*** to my child's treatment.

PAYMENT POLICY

I understand that unless otherwise arranged, payment for professional service is required ***on the day*** treatment is rendered.

TESTS, PROCEDURES

I may be asked for consent to the use of photographs, x-rays, impressions and/or other laboratory diagnostic tests when they are indicated for the purpose of diagnosing and planning treatment.
I may be asked for consent to the use of local anesthetic and other methods of pain control to make me more comfortable while receiving dental treatment.

RECORDS

I understand that all original dental records, x-rays, and diagnostic aids are the property of the MVFD and cannot be removed or sent from MVFD. Copies will be provided upon request of a Dentist or Physician, there will be a $35.00 charge for all duplications of records.

I ACKNOWLEDGE THAT I HAVE READ THE ABOVE INFORMATION.

SIGNATURE

_____ Date_____

Patient or responsible party (age18 or older)

HIPPA PRACTICE ACT

Notice of Privacy Practices

I also acknowledge that I have the opportunity to read, or have read a copy of **Notice of Privacy Practices**.

Patient Name (Printed) _____

Patient/Parent/Guardian Signature _____Date_____