

**PROFESSIONAL DENTAL ASSOCIATES**

**PATIENT CONSENT**

By signing below, you consent to the use and disclosure of your protected health information by **Professional Dental**, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices (“Notice”). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this [facility/office] at (732) 821-0500 and requesting a revised Notice. We will also post any revised notice in the [facility/office].

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, You may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

You have my consent and authorization to keep a record of my signature to submit claims on my behalf as requested and required by my insurance company.

I hereby consent that any dentist or staff may take diagnostic x-rays, photos, and/or models deemed necessary by the dentist to properly and effectively diagnose and determine treatment. **I understand that I will be responsible for any expense that may incur regardless of insurance. You may choose to refuse consent we have the right to refuse treatment.**

Name \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient \_\_\_\_\_

**PLEASE RECORD THE EXACT REASON THE PATIENT OR PATIENT REPRESENTATIVE REFUSED TO SIGN CONSENT, AND NOTIFY THE PATIENT OR PATIENT REPRESENTATIVE THAT WE HAVE THE RIGHT TO REFUSE TO TREAT HIM/HER SHOULD HE/SHE REFUSE TO DICLOSE PROTECTED HEALTH INFORMATION.**

\_\_\_\_\_  
Employee Signature:

\_\_\_\_\_  
Date: