HAYWOOD COUNTY HEALTH AND HUMAN SERVICES AGENCY

PUBLIC HEALTH SERVICES DIVISION- DENTAL CLINIC

Consent for Services

Patient Name_____Birthdate:_____

I have been given specific information on the benefit and risks of the recommended treatment or screening today. I have been told about safety, effectiveness, potential side effects, complications and danger signs, as well as possible alternatives. I know that if any problems are found suggestions will be made concerning follow up and it is up to me to follow-up. I will let the clinic know of changes in my address and/or telephone number so that I may be contacted quickly. If my exam or lab work identifies any problems, staff may refer me to another clinic or provider for help and my records will be sent to the new provider or clinic. I hereby give consent for myself, my child, or the person of whom I am the legal guardian to receive dental treatment deemed necessary by the providers at the Haywood County Health and Human Services, Public Health Services Division- Dental Clinic. This consent shall be considered in effect until rescinded or revoked.

_____ _____

(print name) (relationship)

Signature _____ Date_____

This section needs to be completed for children under the age of 18 or disabled adults by a parent or legal guardian ONLY.

I affirm that I am the parent or legal guardian for the above named minor child or disabled adult. If I am unable to accompany, I give permission for the individuals named below to have access to the above patient's appointment information, to bring the patient to dental appointments, and to make any dental treatment and emergency care decisions necessary for the patient. **Parent or guardian must remain with the patient for the duration of the appointment.**

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship_____

Name:_____Relationship_____

FOR ADULTS: If you would like any other person to have access to your appointment information, please list their name and relationship below.

NAME: RELATIONSHIP

_____ _____

_____ _____

_____ _____

Please initial:

_____ I hereby consent to the release of current x-rays for referrals from this office or to a dental office at my request.

_____ I understand that I am responsible for all insurance co-pays, deductibles and for paying any remaining balance.

_____My medical information is strictly private and is protected by North Carolina law 130A-143, federal regulations of HIPAA. Staff will not share or send this information to anyone unless (1) I tell the staff in writing they can share it (2) staff needs the information to provide services at this clinic (3) it is required by law. A copy of the "Notice of Privacy Practices" will be given upon my request.