PATIENT CONSENT: Please initial each section & sign at the bottom

_____***General Consent:*** I certify to the best of my knowledge, the questions on the forms have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of the staff, responsible for any errors or omissions that I may have made in the completion of this form. It is my responsibility to inform the office of any changes in my status, health, insurance (if applicable), or any of the above information. I grant my permission to you or your assignees to telephone me at home or at my work to discuss matters related to this consent, my treatment, or my account.

_____***Insurance:*** We are happy to work with your carrier to maximize your benefit and directly bill them or reimbursement for your treatment. I authorize Northwoods Dentistry to release any information including the diagnosis and records of treatment or examination for myself and my dependents(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice. I understand that I am financially responsible for any outstanding balance for services provided to myself or my dependents that are not fully covered by insurance, and that I will be billed for any remaining balance. I understand that unless other arrangements are made prior to treatment, accounts are to be paid on the day services are provided.

_____***Financial Policy:*** Northwoods Dentistry requires payment day of service. For larger, more comprehensive treatment plans, we accept payment in thirds, with the first payment being due the day of service. We accept cash, check, Visa, MasterCard, Discover, or American Express. Northwoods Dentistry offers Easy Pay, a service where we can maintain your credit or debit card number on file to satisfy all co-payments, deductibles, and balances (this service is required for payments in thirds). We also offer convenient monthly payment options from Care Credit or Lending Club. If full payment on the account is not received within 90 days, your account will be turned over to our collection agency, Resource Management, Inc. There is a $25 fee charged for patients who miss or cancel without 24-hour notice. Northwoods Dentistry charges bank fees for returned checks.

_____***Social Media/Audio:*** I authorize Northwoods Dentistry to use my photographs, video recordings, and audio recordings on, but not limited to, their website and social media pages for promotional purposes including, but not limited to, advertising, publicity, commercial or display of use. I also authorize Northwoods Dentistry to use my name on such media. I agree to the release and hold harmless Northwoods Dentistry and all employees from any liability related to the making or use of these photographs, video recordings, and audiorecordings for the purposes stated above.

_____***HIPAA:*** I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communicating among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing competence

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any changes to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____***Treatment Consent:*** I understand that I have the right to accept or reject dental treatment recommended by the dentist and will not consent until all potential benefits, risks, and complications have been discussed and all questions answered to satisfaction. By consenting to treatment, I acknowledge my willingness to accept known risks and complications, no matter how slight the probability of occurrence. I agree to follow the dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. I understand if I fail to follow the advice of the dentist, I increase my chance for poor outcome. I agree to the use of anesthetics, sedatives and other medication as necessary to receive treatment. I understand that the use of medications, anesthetics, and some procedures embody a certain risk. I acknowledge that no guarantee or assurance have been given by anyone as to the results that may be obtained with treatment.

Signature: _____ Date:____/_____/_____ Printed Name: _____

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need!

NORTHWOODS DENTISTRY