GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Dr. Hugh's Dental P.C. to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Dr. Hugh's Dental P.C. to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Dr. Hugh's Dental P.C. choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Dr. Hugh's Dental P.C. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/ the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a 1 1/2% finance charge (18% annually) or minimum of $20.00 rebilling fee that will be applied to any balance over 30 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Dr. Hugh's Dental P.C. and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Consent:

Name of Patient ____ ____ **Date** _________________

Signature of Patient/Guardian

Emergency Contact

Name ___________________________________ **phone number**_______________________________________

Notice of Privacy Practices (below)

As a medical office , we are required applicable federal and state law to maintain the privacy of your health information. We are required to provide you with this notice regarding our privacy practices, our legal duties, and your rights concerning your information.

If you would like to review our "Notice of Privacy Practices: brochure available at the reception desk.

Acknowledgement of receipt of notice of privacy practices.

____ **Date** _________________

Signature of Patient/Guardian

I also give permission to discuss my insurance, appointments, treatment and account information to the following people:

Print name	Relationship	Date
		/ /
		/ /
		/ /

CONFIDENTIAL