TO OUR PATIENTS: Before you begin treatment at Dakota Dental and Implant Center, the law requires that we explain your rights and responsibilities while a patient here. Please read and sign the form below. Ask questions if there is anything you do not understand.

_____**CONSENT FOR TREATMENT**: I hereby consent to and authorize the attending doctor, his/her assistants and dental hygienists to perform such examinations, treatments, laboratory tests, operations and to administer such medications as deemed necessary or advisable. This consent also includes all routine diagnostic radiology procedures. My personal health information may be used for my treatment.

_____**RELEASE OF MEDICAL AND/OR DENTAL RECORDS**: In order to insure proper follow-up and continuity of care, I agree that a copy of my medical or dental records, may be released to my dentist, physician, referring dentist, physicians and/or other health or dental care providers. I also agree to the release of my dental records to accrediting/regulatory agencies and to any affiliate of Dakota Dental and Implant Center who may provide health care services to me not limited to dental care operations.

_____**INSURANCE ASSIGNMENT OF BENEFITS**: I request the payment of authorized benefits be made to Dakota Dental and Implant Center on my behalf for any services furnished to me by them. I assign the benefits payable for dental services to the dentist or organization furnishing the services. In consideration of my visits, I agree to pay Dakota Dental and Implant Center for all charges not covered by any third party payer.

_____**RELEASE OF DENTAL RECORDS FOR BILLING PURPOSES:** I authorize Dakota Dental & Implant Center to release information about me, my dental work, dental records, etc to any insurance company, third party payer, state medical assistance agency, other government or private payer deemed responsible for paying insurance benefits as well as information and/or records needed to determine said benefits or benefit related services.

PATIENT'S RIGHT TO PRIVACY: I acknowledge that I have been made aware of Dakota Dental & Implant Center's privacy practices, which were made available to me.

I UNDERSTAND I HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, AT ANY TIME EXCEPT WHEN DAKOTA DENTAL & IMPLANT CENTER HAS ALREADY MADE DISCLOSURES BASED ON HAVING THIS CONSENT ON FILE.

today's date _____ patient's date of birth _____

patient's name _____

signature of patient or parent/guardian _____

relationship to patient _____