Hedrick Family Dentistry
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## Consent for Treatment Plan

**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

I understand and except the treatment presented. I understand that fees may vary at the time of service due to the extent of unforseen treatment. Patient portion are ESTIMATES ONLY and are not a guarantee of payment by the insurance company. I understand the payment of this account is my responsibility. The fees on this treatment plan are valid for 3 months from the date issued. I understand the office will file a pre-estimate upon my request with my insurance company. Again, I understand that I am responsible for the payment on this treatment and will assure restitiution for all services perfomed.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

**Relationship to Patient:**

_____

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**Response Date:** _____