Gandy Dental

1. **Consent to Treatment:** I hereby consent to receive dental treatment deemed necessary by the providers at Gandy Dental. These procedures include, but are not limited to: examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia.
2. **Responsibility to Disclose Information:** Each patient has the right to consent to or refuse any proposed procedure or therapeutic treatment. I understand I should speak out and tell my health care provider if there is anything I do not want done. The health care provider will explain the nature of my condition and treatment and the other ways that this condition could be treated, if any. He/She will explain significant risks involved with the treatment, if any.
3. **Right to Review and Copy Denal Records:** I understand that I have a right, upon written request and with reasonable notice, to inspect and receive a copy, at my expense, of my Dental record and x-ray reports during regular business hours. I also understand that I may authorize other persons to review and copy my Dental record by signing a dated statement which identifies the person, the purpose of the disclosure, the type of information to be disclosed, and the time period during which disclosure to the person is permitted. I understand that I may revoke this consent to disclose confidential information at any time, except to the extent that the medical center, its employees and/or agents, may have already acted in reliance on it, and that, except for such revocation, it will remain in full force and effect for one year from the date of my signature.

5. **Consent to Photograph:** I understand that photographs, videotapes, digital or other images of me may be recorded for the purpose of treatment and/or documentation in my record. I hereby consent to the use of these images for this stated purpose only. I also understand that if Gandy Dental or others request to photograph or take images of me for any purpose, a written consent to do this must be obtained from me prior to being done.

6. **Personal Valuables:** Patients are discouraged from bringing valuables to the dental clinic. Gandy Dental will not be responsible for valuables not deposited in safekeeping.
7. **Financial Agreement/Assignment:** I request that payment of authorized benefits for this treatment be made on my behalf to, and hereby assign benefits directly to, Gandy Dental. I hereby assign the benefits payable for provider services to the provider/organization furnishing this service or authorize such provider / organization to submit a claim to Medicare or Medicaid for payment to me. I understand I am financially responsible to the dental clinic for charges not covered by this assignment and agree to pay those charges. All charges are payable in full 30 days from date of discharge/service or third party payment. In the event that legal action is necessary to collect this account, I agree to pay reasonable attorney fees and collection expenses. Delinquent accounts shall bear interest at the maximum legal rate.
12. I have read the above and understand it. Any questions that have arisen or occurred to me have been answered to my satisfaction.

_____
Patient Name

_____ _____
Patient Signature Date / Time

Patient is a minor or is unable to consent because: _____

_____ _____
Signature of Parent / Legal Guardian / Authorized Representative Relationship to Patient

_____ _____
Witness Date