General consent for Dental Treatment

1) **Consent**: I consent to routine dental care, diagnostic procedures, drugs and therapeutic treatments as are deemed necessary by my providers. I recognize that while in the office of Dr. Gregory Apsey, the patient is under the care of the attending provider and that the dental office personnel render services to patients pursuant to the instructions of the providers. I know if I have any questions about my medical care or tests, I should be sure to ask the doctors/hygienists/staff about them. I know it is up to me to tell the doctors/hygienists/staff about any health problems or allergies I have. I must also tell the doctors/hygienists/staff about drugs or medications I am taking. I understand that an HIV (human-immune deficiency virus) and/or an HBV (hepatitis B virus) or HCV (hepatitis C virus) test will be requested of me if a dental office employee sustains percutaneous, mucous membrane or open wound exposure to my blood or other bodily fluid. I agree to have these tests performed.
2) Contract For Services: I agree to pay in full any and all charges for Dr. Apsey's dental services not otherwise covered by insurance benefits. I assign and authorize payment to be made directly to Dr. Gregory Apsey of all dental benefits otherwise payable to me, but not exceeding the charges for this period of treatment. I certify that any and all information provided by me in furtherance of my application for dental care benefits are true and accurate. I agree to update my insurance information whenever changes occur or if I receive a new policy. I agree to have a credit check done if Dr. Apsey deems it necessary. For patients holding dental insurance plans under which Dr. Gregory Apsey is not a participating provider, I understand that I will be responsible for the cost at the time of the procedure and that I will be reimbursed by my insurance company. Dr. Gregory Apsey's staff will bill my insurance and will use reasonable efforts to work with me to straighten out any problems that may arise in dealing with the insurance company.
3) **Release of Information**: I authorize the dental office and each provider who treats me to release to any party responsible for payment for patient care, such information from the dental records as is required in order for the dentist/hygienist to obtain payment and to any participants in audits of such payments. This authorization to release information for purposes of payment includes dental records. This authorization is effective only so long as necessary to obtain complete payment or reimbursement and will end when complete payment or reimbursement is received. In the event that I have transferred from another dental office, I hereby specifically authorize any and all other dentists from whom I have received services in the past to release dental X-rays and records to Dr. Gregory S. Apsey upon written request for the same. This authorization will be valid only until such time when I notify my new dentist that I am no longer a patient of Dr. Gregory Apsey.
4) **No Guarantee:** I understand that the practice of dentistry is not an exact science and that no guarantee or promises have been made to me as to the result of treatment and/or diagnostic procedures at the office of Dr. Gregory Apsey. I understand that no contract, warranty, guarantee, or promise concerning the results of dental treatment is made. This consent to treatment form is not a contract, nor is it an offer to contract, nor is it an acceptance of an offer to contract. I further understand and agree that Dr. Gregory Apsey will not be liable for the loss or damage to any personal property.

Photostatic copies of this agreement and the signatures below, shall be considered the same as the original. I have read this form. It has been fully explained to me, and all of my questions about the form have been answered, I understand its' contents.

Signature of patient date

Signature of Patient Representative date

Relationship to patient

Witness date