Ron T. Williamson DDS

1964 W. 11 Mile Road Suite 4

Berkley, Michigan 48072

GENERAL CONSENT FORM

SECTION A: PATIENT INFORMATION

Patient Name: _____

SECTION B: CONSENT TO TREATMENT

I do hereby authorize and request the performance of dental services for me and the use of whatever procedures Dr. Williamson may deem necessary for treatment. I understand that Dr. Williamson and staff will use clinical and patient management techniques that are reasonable, necessary and advisable. I also authorize the administration of anesthetics or analgesics which may be deemed advisable to Dr. Williamson and staff.

I understand that any treatment plans presented, along with the fees outlined, could change depending on the time elapsed since the initial examination and extent of dental pathology. Occasionally, once the treatment plan has been started, complications may arise which dictate additional procedures or treatment. Dr. Williamson and staff will always advise you of any changes.

In the event that any team member at Dr. Williamson is exposed to my blood or other bodily fluids, I agree to have my blood drawn and tested for Hepatitis B virus (HBV), Hepatitis C virus (HPV), and the human immunodeficiency virus (HIV). I understand that this testing would be done in a confidential manner, and would be made available only to the person who was exposed, and that person would be advised of my rights regarding protected health information.

48 HOUR CANCELLATION NOTICE

We ask that you would please give us a 48 hour notice before canceling your appointment, please be aware that we reserve and block this time to care for your Dental needs. There may be fees that apply if you do not give us this notice.

SECTION C: FINANCIAL RESPONSIBILITY

I agree to be responsible for full payment of all charges for dental services performed on me. If for any reason the insurance company does not pay their estimated portion, I agree that I will be responsible for my account and the remaining balance. In the event my account is placed with a third party collection agency or attorney, I will be assessed any fees relating to this action.

SECTION D: HIPPAA AUTHORIZATION FOR MARKETING AND EDUCATION

I authorize Dr. Williamson and staff to use or disclose information about my dental and/ or medical condition for marketing and/or education purposes. The possible uses of this information include: (a) as a story in Dr. Williamson brochure or written article, (b) as a website profile or before/after piece, (c) as part of a video, film or advertisement for marketing/public relations purposes.

I understand that this authorization may be revoked at any time to the extent that use or disclosure has not already occurred prior to your request for revocation. Please refer to Dr. Williamson Notice of Privacy Practices for further details on this process.

Dr. Williamson and staff will not condition treatment, payment, enrollment, or eligibility for benefits on the execution of this authorization. The Protected Health information used or disclosed as a result of this authorization may be subject to re-disclosure by the person or entity receiving such information, and thus is no longer protected by the federal privacy regulations. Any photos or images taken become the property of Dr. Williamson and staff or its representatives. The authorization is given without promise of compensation. The parent/legal guardian and the patient release to Dr. Williamson and staff any right, title and/or interest of any kind they may have in the information or images produced.

SECTION E: CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have been offered a copy of and have had full opportunity to read and consider your Notice of Privacy Practices. The notice provides a description of treatment, payment activities and healthcare operations, of the uses and disclosures that we may make of your protected health information, and of other important matters about your protected health information.

I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information as described on the Notice of Privacy Practices to carry out treatment, payment activities and health care operations.

SIGNATURE

Patient Signature:_____ Date_____

If the patient is a minor, or if this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Signature of Parent, Guardian or Personal Representative:_____

Printed name of Parent, Guardian or Personal Representative:_____

Relationship to Patient:_____Date:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

RON T. WILLIAMSON, D.D.S
1964 W. 11 MILE ROAD, SUITE 4
BERKLEY, MI 48072
(248) 399-4455

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ , have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)