

Ellsworth & Warren Family Dentistry
111 W Wigwam Blvd Suite A
Litchfield Park, AZ 85340-4644
(623)935-9376

PATIENT CONSENT FORM

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in any medical status. I authorize the dental staff to perform any necessary dental services, such as x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. I also authorize the doctor (and his/her employees for assistance when applicable) to perform any and all forms of treatment, medication and therapy with my informed consent in connection with my diagnosis and treatment plan. Even though I may have dental insurance coverage, I understand payment for services rendered is my responsibility. It is my understanding that payment is due at the time of service, unless other financial arrangements have been made.

Patient Signature _____ Date _____

Financial Coordinator _____ Date _____

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a notice of Privacy Practices and the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of the Consent.

This consent was signed by: _____

Print Name

Relationship to Patient (if other than patient): _____

Date _____ / _____ / _____

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