ADVANTAGE DENTAL

ACKNOWLEDGEMENT AND CONSENT FORM

You are entitled to a copy of this Acknowledgement and Consent.

Our Notice of Privacy provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of Advantage Dental's Notice of Privacy Practices by initialing here: __________ (Patient's / Parent's Initials).

Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, we will issue a revised Notice of Privacy Practices containing the changes.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions. If we do, we are bound by our agreement with you.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and dental health care services. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

Signature: ____Date: ______________________

Print Name: _____________________________________ Date: ______________________

Street Address: ____

City: ____State: _______Zip: ______________

Telephone: ________________Cellular: _______________E-Mail: ____________________

If this consent is being signed by a personal representative of the patient, provide the following information (Please Print).

Personal Representative's Name: ______________________________Date: ______________

Patient's Name: ___________________________ Relationship to Patient: _______________

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