Patient Consent to Treatment

I hereby give Mainely Teeth permission to treat me today. By signing below, I acknowledge that Mainely Teeth will provide preventive care only at the first appointment and will establish care with a dentist employed by Mainely Teeth at our brick-and-mortar office for yearly routine comprehensive/periodic exams, and all other needed dental services; excluding orthodontic treatment, endodontic treatment, complex oral surgery, implants or veneer services. If we are unable to provide the treatment needed, patients will be given a specialist referral.

Health Insurance Portability & Accountability Act of 1996 (HIPAA)

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that the organization has the right to change its Notice of Privacy Practices from time to time and then I may obtain a current copy of Notice of Privacy Practices.

I understand that I'm requesting in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

X_____ X_____

Name of Patient or Guardian Signature of Patient or Guardian