Jeffrey A. Arnold, DDS, PC
General, Family, Cosmetic & Implant Dentistry
4801 W. Peterson Ave., Ste 311, Chicago, IL 60646 (773)777-7780
1500 Shermer Rd., Ste 222E, Northbrook, IL 60062 (847)564-2205

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

☐Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).

☐Obtaining payment from third party payers (my insurance company).

☐The day to day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under **HIPAA**. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to that date I revoke this consent is not affected.

Signed on:_____, 20_____. (Date)

Print Patient Name:_____

Relations to Patient:_____

Signature:_____

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PATIENT CONSENT FORM FOR SERVICES

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutual agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

Signed on:_____, 20_____. (Date)

Print Patient Name:_____

Relations to Patient:_____

Signature:_____