

Liberty Dental Care, Inc.
207 W. Front Street
Liberty, SC 29657
864-843-3742

CONSENT FORM

I hereby grant my consent for treatment and/or diagnostic examination at the office of Liberty Dental Care, Inc. This treatment may not be limited to the following:

- A. Observation and examination of the tissues of the mouth and related structures (for example: tongue, throat, cheeks, probing the gums, etc.)
 - B. X-rays.
 - C. Cleaning of the teeth and other gum related treatment (for example: gum surgery)
 - D. Administration of an anesthetic (for example: numbing of the tooth, teeth, or gums).
 - E. Administration of an inhalation analgesic (for example: nitrous oxide-laughing gas).
 - F. Extraction of a tooth or teeth (for example: pulling of the tooth or teeth).
 - G. Filling of the tooth or teeth with a temporary or permanent filling (including caps, crowns, or bridges).
 - H. Root Canal Therapy (for example: revoke the nerve of the tooth).
 - I. Replacement of missing teeth with partial/complete dentures, and/or restored implants.
 - J. Other.
- 1) I understand all diagnostic aids such as x-rays, photographs, recordings, testimonials, and drawings which may be deemed necessary or desirable may be taken, and will remain the sole property of Liberty Dental Care, Inc., which may be used all or in any portion thereof for educational purposes, advertising, and/or other marketing purposes.
 - 2) I understand that this examination DOES NOT GUARANTEE further treatment at the office of Liberty Dental Care, Inc.
 - 3) I understand that anyone with financial interest will be given consent to receive any/all information deemed necessary.
 - 4) **Insurance Patients:** I understand that the total fee charged is my **obligation**. Liberty Dental Care, Inc., as a courtesy, will file my insurance. Once my insurance has paid, I will be responsible for the remaining balance. If my insurance carrier does not pay within 60 (sixty) days following my claim submission date, the entire balance becomes my **responsibility** and is subject to an 18% APR finance charge.

My signature, or that of my representative or witness, indicates that I do understand the above, and give my consent for dental treatment and sharing of any information related to the payment by any Third Party.

PERMISSION TO GIVE MEDICAL INFORMATION

I hereby authorize Liberty Dental Care, Inc., to give any of the following people information concerning my health and well-being: 1 _____ 2 _____ 3 _____
I understand that I may revoke this consent at any time by giving written notice to any Liberty Dental Care, Inc. staff member.

ACKNOWLEDGEMENT OF OFFER TO RECEIVE A COPY OF LIBERTY DENTAL CARE'S NOTICE OF PRIVACY PRACTICES

(HIPAA-Healthcare Insurance Portability and Accountability Act)

"You May Refuse To Sign This Acknowledgement"

By my signature, I acknowledge understanding and agree to all of the above and I also acknowledge that I have been offered a copy of Liberty Dental Care's Notice of Privacy Practices (HIPAA).

(PRINT) _____ Date _____
Patient Name

(18 and over) _____ OR (Under 18) _____
Patient Signature Legal Representative Signature