



### GENERAL CONSENT FORM

Patient Name: \_\_\_\_\_  
Last First Middle

Patient Date of Birth: \_\_\_\_\_  
Month Day Year

1. **I freely consent to dental care** – which may include procedures, treatment options, tests, drugs, and treatments that I may receive at Branham Dental Arts, P.C. I know that I have a right to consent or refuse to consent to any future surgery, procedure or treatment and to discuss it with my health care provider. I know I will be informed of all reasonable treatment options. I know that the practice of dentistry is not an exact science and outcomes may be different for each patient.
2. **I know that my health care records will be used for my diagnosis, treatment planning, treatment, and for billing for services.** I know that Branham Dental Arts, P.C. will do everything possible to keep my records private, and that it is Branham Dental Arts, P.C. policy to provide access to health care and billing records only on the basis of need to know. A copy of Branham Dental Arts, P.C. privacy statement has been given to me, and that additional copies are available if I ask a member of the staff for one.
3. **I agree that Branham Dental Arts, P.C. can release data about protective health information to: (A) Health care providers** for the purpose of helping with future care and treatment. **(B) Third party payers** such as insurance groups, Medicare, Medicaid, and their agents. This also includes those who may be in charge of any part of payment for costs linked to my treatment. **(C) Lawyers** who work for or on behalf of Branham Dental Arts, P.C.; **(D) Regulatory agencies;** **(E) Federal or state agencies as required by law.**
4. **I know that in the course of diagnosis and treatment, body tissues, fluids, and other samples may be taken.** Branham Dental Arts, P.C. may dispose of my body tissues, fluids and other samples in a fitting way without cost to me.

5. Human Immunodeficiency Virus (HIV) is the virus that causes AIDS (Acquired Deficiency Syndrome). **I know that under Michigan law, an HIV blood test may be done on a patient if any health care worker or emergency responder contacts that patient's blood or any other body fluids through the skin, in an open wound, or through the mucous membranes.** If this type of contact occurs, I know that I may be asked to take a blood test. However, I do have a right to refuse. If a test is done, I know that I will be informed of the test results, I will receive advice about what to do, what the results mean and what treatment, if any, is indicated if I so choose.
  
6. Except as barred by any agreement between my insurance company and Branham Dental Arts, P.C. or by state or federal law, **I agree to be responsible for my co-payments, deductibles or other charges for dental or medical services not covered or paid by Insurance or other third party payers. I permit Branham Dental Arts, P.C. to file claims with third party payers for payment and assign all rights and benefits to Branham Dental Arts, P.C. as fitting.** I will help Branham Dental Arts, P.C. to follow up on these claims. I further agree - subject to state and federal law – to pay all costs, lawyer fees, expenses, and interest in the event Branham Dental Arts, P.C. has to take action to collect for services not covered by insurance or other third party payers because of my failure to pay for these services.
  
7. **I know that a HIPAA Privacy and Security policy letter has been given to me and I understand its contents. I know that if I have any concern regarding my dental care, treatment plan, or financial obligations; I will have access to a health care provider or business person who will answer my questions.**

I confirm that I have read and understand this form, or that it has been read and explained to me. I know the contents and agree with the terms in this form. I know this form is valid for care given by Branham Dental Arts, P.C. until it is revoked by my legal representative or me.

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Name of Patient	Signature of Patient	Date
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Name of Parent or Guardian	Signature of Parent or Guardian	Date
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Relationship to Patient (if Patient under 18 years of age)

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Witness Name	Signature of Witness	Date
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