Barth Family Dentistry Authorization/Release for Exam, Performance of Procedures:

I, the patient/parent/guardian of the patient, hereby freely and willingly consent to the performance as well as agree to pay all dental fees that insurance does not cover for a comprehensive examination/emergency examimations, all necessary X-rays which may include, a full mouth series, periapicals, bitewings, panoramic x-rays, digital pictures, prophylatic cleaning/gross debridement and fluoride treatment for minors on my initial, emergency and all subsequent recall visits. I consent to any procedure deemed necessary according to the diagnosis on any examination, and/or any dental treatment/procedures which may later become apparent during treatment. I give consent to correct oral deficiency, abnormality, and/or infection. I consent to the administration of anesthetic agents and/or nitrous oxide as needed for my dental treatment. I acknowledge that no guarantee or assurance is made as to the results that may be obtained from treatment. I understand that a diagnosis and/or treatment may be refused to me if I refuse to consent to an emergency/comprehensive examination and/or any/all of the above stated x-rays. I understand that I reserve the right to ask any questions pertaining to my treatment. I understand that I have the right to deny any/all treatment even if it is against the advice of the doctor regardless if the advise/treatment plan is presented to me orally or in writing. I understand that I am solely responsible for paying for all diagnostic costs not covered by insurance at the time services are rendered with no grace period. **If you are concerned about diagnostic costs, please ask for diagnostic fees in writing PRIOR to being seen.**

Emergency patients that have only had a limited examination, a limited treatment plan and limited treatment preformed are considered NOT to be "A Patient of Barth Family Dentistry". Only after a comprehensive examination is completed and a COMPREHENSIVE treatment plan is printed out and signed by the patient/guardian, is the patient "A Patient of Barth Family Dentistry".

For the purpose of diagnostic examination and to formulate the most appropriate treatment plan for each individual, I consent to photographs, models, closed-circuit television, preparation of drawings and similar illustrative graphic material to be taken of me and used in consultation with fellow dental colleagues. I further consent that **Barth Family Dentistry, PSC** may dispose of any tissue or parts of the oral cavity which it may be necessary to remove.

I, the patient and/or legal guardian, give Barth Family Dentistry, PSC, consent to X-rays and Digital Pictures for diagnostic purposes. I also give my permission to use these digital pictures and x-rays taken of myself, (before, during and after dental treatment) to display in the dental waiting room, dental office, website, internet, email, video, television, fax, etc., to be used as "before and after" and educational tools, and/or consultations with other patients, doctors or the public at large to view, at no fee, and/or liability to Barth Family Dentistry, PSC / Dr. Charity A. Barth. I understand that if I disapprove of my image being displayed in public via digital photography and/or X-rays that I must submit a written, dated and signed letter to Barth Family Dentistry specifically stating that "I do not give my consent to display digital photography and/or x-ray for public view". I understand that if I refuse Diagnostic Digital Pictures or X-rays deemed necessary by the doctor for diagnostic purposes that Barth Family Dentistry has the right to refuse the examination and/or treatment.

I understand and consent that I may be tested for the Human Immunodeficiency Virus (HIV) and Hepatitis B, C or any other blood-bourne diseases in the event of an occupational blood exposure to a healthcare worker. Results will be made available to the Dentist and the employee to whom was exposed. By law, this information is confidential and the above listed people are prohibited to disclose information to anyone else.

I understand that appointments cannot be made after office hours and that I or the person for whom I am consenting, will be expected to be available for treatment during the hours that Barth Family Dentistry, PSC is open.

I authorize Barth Family Dentistry, PSC to release any information and records concerning my treatment as may be necessary to process insurance claims or payment for the care and treatment provided

I understand that for Biohazard & Safety Reasons : Only 1 Adult may join a patient in treatment areas! All Children MUST remain in Waiting Room with a responsible adult! (Our Staff is unable to watch children**!) Patients without a Responsible Adult to watch children in Waiting Room, will not be seen!**

I also understand that any patient 17 years old and younger must have parent or legal guardian present during any and all dental examinations and dental procedures. I also understand that any patient 17 years and younger must have parent or legal guardian approve and sign treatment plan prior to dental procedures.

By my signature below, I certify that I have read, understand, accept and give consent to the above statements.

_____ _____ _____

Print Patient Name or Legal Guardian Signature: Date

Witness : _____ Date: _____ Updated Jan 1, 2016