Dr. Michael Wasson, DMD
Family and Cosmetic Dentistry
2561 Hendersonville Rd.
Arden, NC 28704
828-687-1791

Consent for Treatment and HIPPA Acknowledgement

I hereby authorize Dr. Michael Wasson, DMD, and staff to perform all indicated and agreed upon dental examinations and treatment that have been presented to me. I have been provided with adequate information, in a way I understand, to make a well-informed and confident decision regarding my proposed treatment. I further understand that I may ask any questions I wish, before, during and after my visits.

I am aware that dentistry (like medical), is not an exact science and acknowledge that no guarantees have been made as to the result of any examinations, procedures, or treatments. I further acknowledge that such examinations, procedures or treatments may have unforeseen or unexpected consequences that may result in less than ideal outcomes, including complications that produce increased discomfort or loss of function.

In addition, I understand that in compliance with Federal OSHA procedures, in the event of any exposure to the dentist, staff or patient of blood or other potentially infectious materials, the parties involved shall be deemed to have consented to testing for infectious pathogens to include but not be limited to HIV and Hepatitis, and that appropriate follow-up will be advised.

I have been given the opportunity to review this office's HIPPA Notice describing how medical and dental information about me may be used and disclosed and how I may get access to this information. I have been offered a copy of the HIPPA Notice. In addition, I may authorize the individuals listed below to share my contact, medical and/or dental information. (Leave **blank** if you do not wish to authorize anybody else.)
Names (print):_____

For Parents or Guardians: Do you want to authorize any other adult to participate in your child's treatment?
No___ Yes____ If so, I authorize the adult individuals listed below to bring my minor child (print child's name)_____to dental appointment, and have authority to share my child's protected health information and grant them permission to alter treatment plans as necessary (act on my behalf). Minors will only be seen if accompanied by their parent, legal guardian or authorized adult persons listed below:
Names: _____
Understanding the reasonable benefits and risks to the proposed treatments, I hereby elect consent to treatment and release Dr. Michael Wasson, DMD and staff from any unwarranted liability and waive any and all current or future unwarranted claims against Dr. Michael Wasson and staff, concerning my dental treatments.

_____

Signature (or guardian) **Print Name** **Date**