Consent for Treatment

I hereby authorize Dr. Mason and his associates to perform upon me the procedures necessary for my dental treatment, including the use of Local Anesthetic.

X_____ _____
Signature Date
X_____ _____
Parent/Guardian Signature if a minor Date

Permission to Leave Messages

I give Dr. Mason, his associates, and the office permission to call, send, or leave messages at my home or place of employment relating to my dental services.

X_____ _____
Signature Date
X_____ _____
Parent/Guardian Signature if a minor Date

Please list names of and relationships of individuals with whom you do not want treatment information discussed:

_____ _____
Name Date
_____ _____
Witness Date

I understand that I may revoke this authorization at any time by notifying the office in writing of my desire to do so.

Privacy Practice Acknowledgement Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
Obtain payment from third-party payers.
Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read, and understand your Notice of Privacy containing a more complete description of the used and disclosures of my health information. I understand that Dr. Mason and his associates have the right to change the Notice of Privacy Practices from time to time and that I may contact this office at any time to obtain a current copy of the Notice.

X_____ _____
Signature Date
X_____ _____
Parent/Guardian Signature if a minor Date

☐ PATIENT REFUSED TO SIGN _____