Miami County Dental Clinic
Consent for Treatment/ Release of Medical Information
MCDC Appointment Rules
Patient Financial Responsibility

Consent for Treatment and Release of Medical Information:
I, the undersigned patient, having a condition requiring medical care, do hereby voluntarily consent to be given treatment by an attending physician(s), assistants(s), consultant(s), or designees of the Miami County Dental Clinic, as is necessary in their judgment. Miami County Dental Clinic is not responsible for the acts or omissions of physicians that are not directed or controlled by the dental clinic. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination at MCDC. I consent to being photographed or being recorded by videotape in connection with my diagnosis, care and treatment. Authorization is hereby granted to release medical record information of treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse to another healthcare provider, including faxing of this information, upon my transfer for further care. _____ *Please Initial*

Miami County Dental Clinic Rules:
To keep on time appointments, we need your help. Ten (10) minutes late will be considered a missed appointment. We schedule emergencies by appointment only as well.

Two missed appointments will result in six (6) months waiting period before you will be able to schedule an appointment. You may be able to come for emergency treatment as a "stand by." If you need to cancel your appointment please call the day before your appointment (24 hours). Cancellation calls on the day of the appointment will be considered missed unless approved by the dental staff. _____ *Please Initial*

Financial Responsibility
The clinic insists that you must have your account balance at -0- before you can continue with the next appointment or treatment. The only exception with this policy will be a financial plan and a payment presented to the Clinic Coordinator before the next appointment.

The dental staff appreciates your cooperation. Please sign below that you have read and fully understand consent and are voluntarily signing it.

_____ _____
Witness Date Signature of Patient /Authorized Rep Date