Miami County Dental Clinic

Consent for Treatment/Release of Medical Information

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 the attending physician(s), assistant(s), consultant(s), and/or designees of the Miami County Dental Clinic, as necessary in their judgement. 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. 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 and/or email of this information, upon my transfer for further care._____ (please initial)

Financial Responsibility

The Miami County Dental 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 for treatment and are voluntarily signing it.

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Signature of Patient/Authorized Rep Date