PARAMOUNT DENTAL ARTS

Dr. Todd K. Schild

Signature and Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my (my dependent _____) dental needs.

2. Upon such diagnosis I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to allow Dr. Schild to use any testimonial I give regarding the dental care I receive from any such office, in any marketing contests, advertising or teaching materials used to market or advertise his dental practice including use on Paramount Dental Arts' website and social media sites.

5. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% per month late charge (18% APR) may be added to my account as well as all reasonable collections costs.

_____ _____

Signature (Parent or Guardian if under 18) Date

_____

Print Name

1050 Clifton Avenue, Clifton NJ, 07013 • 973-777-1772 • www.paramountdentalarts.com

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Patient Consent/Acknowledgment Form - HIPAA

By signing below, you consent to the use and disclosure of your protected health information by Paramount Dental Arts, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised notice by simply contacting this office at 973-777-1772 and requesting a revised notice. We will also post any revised notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

This form is also used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgment.
I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

_____ _____

Signature (Parent or Guardian if under 18) Date

_____

Print Name