



Privacy and General Consent

Privacy Consent

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Consent for Treatment

I hereby authorize Paschal Orthodontics and its employees, staff, and agents to take x-rays, study models, photographs and/or any other diagnostic aids deemed necessary by Dr. Paschal to make a thorough diagnosis of me or my dependent's dental needs.

Upon such diagnosis, I authorize Paschal Orthodontics to perform all recommended treatment agreed upon by me, and to give such assistance as required to provide proper care. I understand that I may ask for a full explanation of any possible complications.

Please let us know if you have any questions.

Signature (Responsible Party) _____ **Date:** _____