Nevada Dental Benefits, Ltd.®
a PRIMECARE℠ company

Patient Treatment Consent/Agreement

Consent to Treatment

The undersigned consents to radiographs (x-rays), laboratory procedures, anesthesia, diagnostic tests, dental treatment, or other procedures rendered to the patient under the supervision of Nevada Dental Benefits, Ltd. (NDB) Attending Dentists. Although the undersigned may elect not to undergo certain specific procedures, without adequate diagnosis or treatment plan NDB may decline to treat the patient.

Privacy Practices

The NDB Notice of Privacy Practices is available to the undersigned via our website or in paper from by request. The undersigned consents to the use and disclosure of his/her health information to carry out treatment and health care operations. In order to assist in the improvement of dental care, the undersigned authorizes representatives of NDB to use all or part of the patient's record including written records, radiograph, photographs, videotapes and laboratory reports for teaching so long as the patient is not identified by name in connection therewith.

Patient Rights and Responsibilities

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We reserve the right to change our privacy practices as described in our notice of Privacy Practices.

Financial Agreement

The undersigned agrees, whether he/she signs as agent or as patient, he/she hereby individually obligates himself/herself to pay for treatment received at NDB in accordance with the regular rates and terms of NDB. Failure to pay for services in a timely manner may jeopardize the patient's access to routine dental care. In the event the patient's account is transferred to a bad debt collection agency the undersigned may be responsible for reasonable attorney's fees and collection expenses.

I (print name)_____have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

_____ _____

Signature **Date mm/dd/yy**

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:	
Personal Representative's Name:	Relationship to Patient: