Northwestern Dental Center

TREATMENT AGREEMENT FOR DENTAL SERVICES

I. CONSENT FOR DIAGNOSIS AND TREATMENT

I am visiting Northwestern Dental Center (NDC) voluntarily for the purpose of diagnosis and dental treatment and consent to and authorize diagnostic procedures and dental, x-ray, and laboratory tests or treatment by my dentist, his assistants or designees as are necessary in their judgment. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as the result of treatment or examination at the Dental Center. I hereby authorize NDC to retain, preserve, and use for scientific or teaching purposes, or dispose of at their convenience any specimen or tissue taken from my head and neck region during my dental visit.

II. RETENTION OF INFORMATION

I understand that NDC may record medical/dental and other information concerning my treatment in electronic and other physical form. Such information is required in the course of my treatment, and may be released by NDC for the purposes authorized on this form. I understand that portions of my records may be disclosed to qualified non-hospital personnel for the purpose of conducting scientific or statistical research, management or financial audits, licensure, and program evaluation or other similar purpose. I will not be identified by name or other personally identifying information in any report of such research, audit, or evaluation without my express consent.

III. RELEASE OF INFORMATION/ ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I (the undersigned) authorize NDC to act on my behalf in connection with any claim for coverage or benefits, including receipts of any approvals or authorizations that are required before dental services. I authorize my representative to receive any and all information that is provided to me, and to act for me in providing any information to the group health plan that relates to any claim for coverage or benefits under this group health plan. Further, I authorized NDC to release any dental/medical information concerning this treatment to dentists/ physicians and clinicians associated with NDC who are my oral healthcare providers. I may revoke my authorization and consent at any time and for any reason by providing written notice to NDC. This authorization shall not conflict with any internal policy regarding release of information which will have priority. This authorization is not intended to allow the release of records regarding my treatment for services requiring a restricted release under State or Federal Law.

In consideration of the dental services provided to me by NDC, I hereby assign to NDC and dentists and other professionals associated with the dental center all of my rights and claims for reimbursement under any dental insurance or any other group/individual accident or health insurance policy for which benefits may be available for payment of the services provided. I agree to pay NDC, the dentists, and other professionals associated with the Dental Center, the balance due to all charges not paid for by the above mentioned coverage. Should it become necessary to turn any of my accounts over to a collection agency, a collection fee not to exceed 25% of the balance referred plus reasonable attorney's fees, court cost, and post judgment interest, if incurred, will be added to my bill.

I HAVE READ the foregoing and **FULLY AGREE** to each of the statements and agreements herein and fully understand that payment for services provided are due at the time of said services which may include emergency or outpatient dental care by signing below as my free and voluntary act.

_____ _____

Signature Date

Patient/ Guardian (if under 18 yrs. old)