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Patient Consent Form

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing except for information already used or disclosed.

I hereby authorize Dr. Klyber's Office to take x-rays, study models, photographs, or any diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorized Dr. Klyber to perform any and all forms of treatment, medications and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I agree that a machine-reproduced copy of this signed authorizations agreement shall be deemed an original.

Signature: _____ Date: _____
Patient, parent or legal guardian

If signed by patient representative, state relationship to patient: _____