ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Cornerstone Dental's Notice of Privacy Practices provides information about how protected health information (PHI) about me (the patient) may be used or disclosed. I have been offered an opportunity to review the Notice, object to the use or disclosure of my PHI, and/or request restrictions as to how my PHI may be used or disclosed for treatment, payment, or healthcare operations before signing this consent. Cornerstone Dental is not required to agree to any restrictions, but if they agree, will be bound by the agreement. I understand that the terms of the Notice may change and I may obtain a revised copy by contacting the office at (585) 865-7030 or by visiting the office's website at www.cornerstonedentalny.com. I also understand that by refusing to sign this consent or revoking this consent, Cornerstone Dental may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I authorize Cornerstone Dental to discuss and/or release my PHI to the following individuals:

_____

_____

I wish to have the following restriction with regard to the use or disclosure of my PHI:

_____

_____

FOR OFFICE USE ONLY

Attempts were made to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify): _____

EE Initials: _____

By signing below, I acknowledge that I have received a copy of and understand Cornerstone Dental's Notice of Privacy Practices.

➢ _____

Signature Printed Name Date

CONSENT FOR DENTAL PROCEDURES, TAKING OF X-RAYS, ADMINISTRATION OF ANESTHETICS, AND THE RENDERING OF SERVICES

Patient (print): _____ DOB: _____Date: _____

I hereby request and authorize Cornerstone Dental, any associate dentists, hygienists, assistants, and/or such other qualified personnel as may be selected, to perform Routine Dental Care, a Comprehensive Oral Evaluation and any diagnostics including x-rays and/or any other therapeutic procedure that is in his/her judgment, advisable for the above- named patient's well-being.

The nature and purpose of the procedures and anesthetic, the risks involved, and the possibility of complications have been explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained. The advantages and inherent risks of anesthesia have been explained to me and I authorize the administration of such anesthesia as may be considered necessary or desirable.

I authorize that any specimens, tissue or parts removed from me or the above-named patient be disposed of in accordance with established practice.

In some instances, a referral to a specialist may be indicated. If I or the above-named patient requires the services of a specialist, I agree to accept the referral and will be responsible for any expense that may be incurred.

I hereby acknowledge and agree that if my dental insurance does not cover the treatment authorized above, I will be personally responsible for paying the financial charges for those services.

I certify that I have read this consent, or that it has been read to me, and that I understand the above. I have had an opportunity to ask questions and had these questions addressed to my satisfaction.

➢ _____

Signature of Patient (or Person Authorized to Sign for Patient) Relationship to Patient