

**Ferris State University
Dental Hygiene Clinic
Consent to treatment, Payment and Release of Dental Information**

Patient Full Legal Name: _____

Preferred Name/Nickname: _____ Date of Birth: _____

Parent/Guardian: _____ Relationship: _____

Welcome to the Ferris State University Dental Hygiene Clinic. This facility provides the opportunity for our dental hygiene students to receive their clinical experience in preparation to become licensed professional dental hygienists. The services provided by student dental hygienists are under the supervision of licensed dental hygienists and dentists.

These services include extra and intraoral examination, blood pressure screening, oral hygiene evaluation and instruction, radiographs (x-rays), oral data (periodontal probing, hard tissue charting), oral prophylaxis (preventative cleaning), scaling and root planning (deep cleanings), topical fluoride applications, and pit and fissure sealants.

As a patient in the clinic, you are entitled to considerate, respectful, and confidential treatment which meets the dental hygiene profession's standard of care. You should expect to be informed of the treatment recommended and alternatives, the option to refuse treatment, the risk of no treatment, and the expected outcomes of various treatments. You should expect to know the cost of the treatment in advance. You should expect to be kept informed on the status of your condition and the anticipated length of time for treatment to be completed.

The dental hygiene care that you receive is NOT a substitute for your regular, periodic examination at your own dentist. We encourage you to **contact your dentist for a dental examination** so that he/she can determine if you need additional services such as restorations or other dental care.

From time to time, it may be necessary for us to make disclosures of your information in connection with your treatment and other activities as more fully described in our Notice of Privacy Practices. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing, or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Terms of Service

- I am responsible for payment at the time of the visit for all services provided by the Ferris State University Dental Hygiene Clinic.
- I am responsible for presenting complete insurance information to the Ferris State University Dental Hygiene Clinic prior to receiving services. My signature serves as a "signature on file" for claims processing and for release of dental information to my insurance carrier. If I am unable to provide complete insurance information prior to services being rendered, I acknowledge that I will be responsible to pay for the visit and submit for reimbursement to my insurance company on my own.
- I acknowledge that photographs or information concerning this examination may be used in the interest of education or research. I understand that the data will be de-identified to protect my identity.

****Continued Back of Form****

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- I have complied with all recommendations of my treating healthcare providers for any care recommended prior to receiving dental treatment, including taking any prophylactic antibiotics.
- I authorize Ferris State University to send my dental radiographs or dental records to my private dentist in an electronic format, at my request and send them to the email address provided by the dentist of my choice. I am aware that there is some level of risk that third parties might be able to read unencrypted email.
- I understand that there may be circumstances where I may be reappointed, referred to a private dentist, or denied treatment if it is determined that my obtaining treatment is not in my best interest or that of the Clinic.
- I acknowledge that I was offered and/or received a copy of the Ferris State University Dental Hygiene Clinic's Notice of Privacy Practices. I understand that I may ask questions about these practices at any time.

Consent to Contact

- By supplying my phone number, email address, and any other personal contact information, I authorize the Ferris State University Dental Hygiene Clinic to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me. This information may include the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue dental hygiene visit, or any other reasonable healthcare related communication.

Release of Information

- I authorize the Ferris State University Dental Hygiene Clinic to share my confidential patient information (dental, medical and financial) with the following individuals. Please print clearly.

Name

Relationship

By signing below, I acknowledge that I have read and agree to all items as outlined above.

Signature: _____ **Date:** _____

This Consent expires 3 years from date of signature.