1. I understand that I have certain rights to privacy regarding my health information. These rights are stated under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent, I authorize the Doctors of Wood Creed Dental to use and disclose my health information to carry out the following:
    a. Treatment (including direct treatment by Wood Creek Dental Professional)
    b. Obtaining 3rd party payment (e.g. insurance company, outside financing)
    c. The day to day dental operations performed at Wood Creek Dental.
2. I understand that each of these contains involved risks and ramifications; some of which will be explained to me at the time services are rendered.
3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patient follow post-operative and post-care instructions. Regular office visits as scheduled, must be maintained.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional procedures from those discussed.
5. I understand that failure to proceed with treatment can lead to adverse effects.
6. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, in dental and health publications, and any marketing or advertising.
7. I understand that I have the right to revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent form is not affected.

I have read and understand the material read.

Patient's Name: ______________________

Signature:____________________________Date:_________________________