James J. Hur DDS 1402 – 36th St. SW Wyoming, MI 49509 (616) 534-3362

GENERAL CONSENT FORM

SECTION A: PATIENT INFORMATION

Patient Name: ______________________________ Date of Birth: ________________ Social Security Number: ____________________

SECTION B: CONSENT TO TREATMENT AND FINANCIAL RESPONSIBILITY

I do hereby authorize and request the performance of dental services for me and the use of whatever procedures Dr. James J. Hur DDS may deem necessary for treatment. I understand that Dr. James J. Hur and the assistants that he may designate to treat me will use clinical and patient management techniques that are reasonable, necessary and advisable. I also authorize the administration of anesthetics or analgesics which may be deemed advisable to Dr. James J. Hur DDS.

I understand that any treatment plans presented, along with the fees outlined, could change depending on the time elapsed since the initial examination and extent of dental pathology. Occasionally, once the treatment plan has been started, complications may arise which dictate additional procedures or treatment. Dr. James J. Hur or his staff will always advise me of any changes.

In the event that Dr. James J. Hur, DDS or a staff member is exposed to my blood or other bodily fluids, I agree to have my blood drawn and tested for Hepatitis B virus (HBV), Hepatitis C virus (HCV), and the human immunodeficiency virus (HIV). I understand that this testing would be done in a confidential manner, and would be made available only to the person who was exposed, and that person would be advised of my rights regarding protected health information.

SECTION C: FINANCIAL RESPONSIBILITY

I agree to be responsible for full payment of all charges for dental services performed on me. If for any reason the insurance company does not pay their estimated portion, I agree that I will be responsible for the account. In the event that my account is placed with a third party collection agency or attorney, I will be assessed any fees relating to this action.

SECTION D: CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have been offered a copy of and have had full opportunity to read and consider your Notice of Privacy Practices. This Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information as described on the Notice of Privacy Practices to carry out treatment, payment activities and health care operations.

SIGNATURE

Patient Signature: ________________________________ **Date:** ________________________________

If the patient is a minor, or if this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Signature of Parent, Guardian or Personal Representative: ________________________________

Printed name of Parent, Guardian or Personal Representative: ______________________________

Relationship to Patient: __________________________ Date: ____________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.