



SECTION A: PATIENT GIVING CONSENT

Last Name: _____ First Name: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our 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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by requesting from the practice.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation.

SECTION C: SIGNATURE

I, _____ (Print Name) _____ have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____



NON-DISCRIMINATION POLICY

AP Family Dentistry and its affiliates comply with applicable federal civil rights laws and do not discriminate based on race, color, national origin, age, disability, or sex.

If requested, AP Family Dentistry and affiliates provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

If you need these services, contact the office manager at the practice location.

If you believe that AP Family Dentistry and its affiliates have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Kam Abed- Compliance Coordinator
9203 Mentor Ave,
Mentor, OH 44060
apfamily@apfamilydentistry.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Aziza Abed, Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington,
D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)



Your dentist is the best source of information about your dental health and wants you to feel comfortable about your dental care. Maintaining healthy teeth and gums means more than just brushing and flossing every day and visiting your dentist regularly. As an informed dental patient, it also means knowing what you can expect from your dentist and dental care team and understanding your role and responsibilities in support of their efforts to provide you with quality oral health care.

The rights and responsibilities listed below do not establish legal entitlements or new standards of care but are simply intended to guide you through the development of a successful and collaborative dentist-patient relationship.

PATIENT RIGHTS

1. *You have a right to choose your own dentist and schedule an appointment in a timely manner.*
2. *You have a right to know the education and training of your dentist and the dental care team.*
3. *You have a right to arrange to see the dentist every time you receive dental treatment, subject to any state law exceptions.*
4. *You have a right to adequate time to ask questions and receive answers regarding your dental condition and treatment plan for your care.*
5. *You have the right to know what the dental team feels is the optimal treatment plan as well as the right to ask for alternative treatment options.*
6. *You have a right to an explanation of the purpose, probable (short and long term) results, alternatives and risks involved before consenting to a proposed treatment plan.*
7. *You have a right to be informed of continuing health care needs.*
8. *You have a right to know in advance the expected cost of treatment.*
9. *You have a right to accept, defer or decline any part of your treatment recommendations.*
10. *You have a right to reasonable arrangements for dental care and emergency treatment.*
11. *You have a right to receive considerate, respectful and confidential treatment by your dentist and dental team.*
12. *You have a right to expect the dental team members to use appropriate infection and sterilization controls.*
13. *You have a right to inquire about the availability of processes to mediate disputes about your treatment.*
14. *You have the right to receive access to treatment and accommodations that are available regardless of race, sex, age, creed, sexual orientation, national origin, religion, handicap, or marital status*



PATIENT RESPONSIBILITIES

1. *You have the responsibility to provide, to the best of your ability, accurate, honest and complete information about your medical history and current health status.*
2. *You have the responsibility to report changes in your medical status and provide feedback about your needs and expectations.*
3. *You have the responsibility to participate in your health care decisions and ask questions if you are uncertain about your dental treatment or plan.*
4. *You have the responsibility to inquire about your treatment options and acknowledge the benefits and limitations of any treatment that you choose.*
5. *You have the responsibility for consequences resulting from declining treatment or from not following the agreed upon treatment plan.*
6. *You have the responsibility to keep your scheduled appointments.*
7. *You have the responsibility to be available for treatment upon reasonable notice.*
8. *You have the responsibility to adhere to regular home oral health care recommendations.*
9. *You have the responsibility to assure that your financial obligations for health*

Areas within the practice may be limited to some requests for accommodations specifically where facility must maintain a sterile environment.