

## HILLS FAMILY DENTAL

### **Acknowledgment of Receipt of Privacy Practices and Consent for Treatment**

I have been offered a copy of this office's Notice of Privacy Practices. I give my consent for Dr. Hills and her staff to do a complete and thorough examination on the patient previously named, including any photographs, study models, needed radiographs or other diagnostic aids. To the best of my knowledge, the information I have given is correct and I understand that it will be held in the strictest of confidence. Furthermore, I understand that it is my responsibility to notify Dr. Hills of any future changes to the patient's medical status. I do hereby grant Dr. Hills and his staff permission to perform any needed treatment.

Please Print Patient Name(s) \_\_\_\_\_

Signature (please note relationship to patient if not same) \_\_\_\_\_

Date \_\_\_\_\_