RONALD G. WILKINS, DDS
4020 SOUTH 700 EAST #1
SALT LAKE CITY, UT 84107

PATIENT CONSENT TO PROCEED/ACKNOWLEDGEMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Ronald G. Wilkins, D.D.S., our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at 801-263-2633 and requesting a revised Notice. We will also post any revised Notice in the office. You have the right to request that we restrict our uses or disclosures of your protected health information, which we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

- I authorized Dr. Wilkins and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative, analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.
- I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.
- I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THIS NOTICE OF PRIVACY.

Signature _____ Date _____

Please specify the exact reason why patient chose not to sign the Consent/Acknowledgment of Notice of Privacy.

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