



**Notice of Privacy Practices Acknowledgement:**

I hereby acknowledge that I have been offered or received the University of Michigan School of Dentistry (UMSD) Notice of Privacy Practices.

**Important Patient Information Acknowledgement:**

I hereby acknowledge that I have been offered or received the UMSD Important Patient Information.

**Agreements:**

**1. Assignment of Medical Benefits**

Except as barred by any agreement between my insurance company and UMSD or by state or federal law, I understand that I will be responsible for my co-payments, deductibles or other charges for medical services not covered or paid by insurance or other third party payers. I assign all rights and benefits to UMSD in order to facilitate reimbursement for health care services. I will help UMSD follow up on these claims.

**2. General Consent to Receive Health Care Services**

I freely consent to dental health care – which may include procedures, treatment options, tests, drugs, and treatments that I may receive at the UMSD. I understand that I have a right to consent or to refuse to consent to any future surgery, procedure or treatment and to discuss it with my health care provider. My health care provider will discuss specific care/ interventions including procedures with me and obtain a specific consent. Research, invasive procedures and special treatments require specific consents. I understand I will be informed of all reasonable treatment options. I know that the practice of dentistry is not an exact science and outcomes may be different for each patient.

**3. Acknowledgement**

I acknowledge that I have read and understand this form or that it has been read and explained to me. I have had the opportunity to ask questions and my questions have been answered. I know the contents and agree with the terms in this form. I understand this form is valid for any care given by UMSD until it is actively revoked by my legal representative or me.

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Patient Name	Patient Signature	Date
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Witness Name	Witness Signature	Date
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