ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES AND LIABILITY/IMAGE RELEASE

I have been told that the success of my dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status. I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

I understand, and it has been explained to me, that there are some risks in the administration of local anesthetics. I give permission for the use of local anesthetic and any anxiolytic and/or sedative medications that may become necessary. The possible side effects of local anesthetics are prolonged or permanent numbness of the lips, cheeks, or gums, rapid heart rate, allergic reactions, and reactions with other drugs that I am taking. I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the injection(s), I agree to report them to the dentist as soon as possible.

There are certain inherent risks in any dental therapy. We do not expect these risks to occur but they may be, but not limited to, cracked lips, hypersensitive teeth, Temperomandibular Joint soreness, need for further treatment such as a root canal, inflammation, a change in the bite, damage to adjacent teeth, and allergic reactions. I understand and permit the doctor to alter the treatment plan during treatment when unforeseen circumstances are met or in order to avoid the risks mentioned above. I also understand that due to pigmentation differences and natural discoloration or decalcification it is not always possible to match the shade of adjacent teeth exactly. I agree to have necessary X-rays administered to prevent developing problems and understand that, even with a digital system, a low dosage of radiation is used.

I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for al least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). If I elect to have nitrous oxide in conjunction with my dental treatment, I have been informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, vomiting, dizziness and headache. I understand that nitrous oxide use is not indicated if I am pregnant.

I agree to the use of my testimonial and/or photographs to be used by Ann Arbor's Dentist as participation in raffles, website, social media, and any other events. I acknowledge that I will not receive compensation for my testimonial and/or photographs.

I acknowledge that I have been given the opportunity to read and recieved a copy of Ann Arbor's Dentist's HIPPA Notice of Privacy Practices.

Signature of Patient *(or guardian)*_____***Date***_____

We are here to serve you. We practice the "Golden Rule" and expect you'll do the same. Ann Arbor's Dentist will respect your time and in return, please respect ours as well as that of other patients. In order to accomodate all patients, we have a strict 48 hour cancellation policy that will result in a $50 fee if broken. We offer premium late night and weekend appointments; a failure to honor these appointments may results in additional fees. Multiple missed appointments will lead to dismissal from the practice.

Signature of Patient *(or guardian)*_____***Date***_____