PATIENT NAME: _____

STONEWOOD DENTAL

CONSENT TO TREAT

I HAVE READ AND COMPLETED THE PATIENT INFORMATION FORM AND DO HEREBY CONSENT TO TREATMENT ON MY BEHALF OR OF THE MINOR NAMED ABOVE. IF FOR A MINOR, MY SIGNATURE ALSO REPRESENTS THAT I HAVE LEGAL AUTHORITY TO CONSENT TO TREATMENT IN HIS/HER BEHALF.

SIGNED: _____
(PATIENT, PARENT OR LEGAL GUARDIAN)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ **Individual refused to sign**
_____ **Communications barriers prohibited obtaining acknowledgement**
_____ **An emergency situation prevented us from obtaining acknowledgement**
_____ **Other (Please Specify)** _____