Your Informed Consent For Treatment

Thank you for placing your trust in us! In order for us to provide you with the best possible care and service, we simply need your permission. Please read the following carefully, and print your name and sign where indicated. Please don't hesitate to ask us ANY questions you may have. It is truly our pleasure to help you!

AUTHORIZATION

I authorize Dr. Michael K. McKinney or Dr. Veronica McKinney and their professional staff to perform any appropriate diagnostic procedures and treatment as may be necessary for proper dental care and oral health; gather a complete and accurate dental and medical history to aid in diagnosis and any necessary treatment planning; inform me of any dental conditions currently present, including their estimated levels of severity and projected paths of progression; and make any necessary treatment recommendations, including any known, available options, and their risks and benefits, to correct any diagnosed conditions;

PRIVACY

I authorize the release of any and only relevant information concerning my medical or dental health to any appropriate dental or medical practitioners, selected by me or Dr. Michael McKinney or Dr. Veronica McKinney, on an "as needed" basis, to assist them in my care. Otherwise, **all information is to be kept strictly confidential**.

MULTIMEDIA RECORDS

I authorize the right and give permission to copyright and/or publish, or use my written or spoken statements, or photographic pictures of me, or those in which I may be included in whole or in part, or reproductions thereof made through any form of media, for art, advertising, trade, or any other lawful purpose, as individually agreed upon by me, including the use of my own name in whole or in part. I hereby waive any right to inspect and/or approve the finished product or the copy that may be used in conjunction with it, or the use to which it may be applied. I hereby release, discharge, and agree to save the practice, doctor, and staff from any liability for any blurring, distortion, optical illusion, alteration, or use in composite form, whether intentional or otherwise, that may occur or be produced in the use of said materials, or in any processing tending toward the completion of the finished materials. I understand cosmetic imaging may not be the same as final treatment results. Note: We will never use any of the above materials for promotional purposes without your express permission.

INSURANCE

I authorize the release of any relevant information concerning my medical or dental health to my insurance company for the purpose of evaluating and administering claims for insurance benefits. I authorize payment of insurance benefits, which would otherwise be payable to me, directly to Dr. Michael McKinney or Dr. Veronica McKinney's office, unless alternate arrangements are made, and only after my insurance information has been verified by the doctors and their staff.

Signed ______________________________ Date _____ - _____ - _____

Patient (or Parent/Guardian if Patient is under 18)

______________________________ ______________________________

(Please Print Name) Patient's Name (if under 18)