Fit Smile
DENTAL HYGIENE

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Authorization and Release

I certify that I have read and understand the above questions to the best of my knowledge and the above questions have been accurately answered. I understand that providing incorrect or withholding information can be dangerous to my health.

I authorize the Dental Hygienist to release any information including the Dental Hygiene diagnosis and the records of any treatment or examination rendered to the named client during the period of such Dental Hygiene care to third party payers and/or health practitioners for insurance and health related referral purposes only. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize payment directly to Dhonabel Lacsamana, RDH with Fit Smile Dental Hygiene from any group insurance benefits otherwise payable to me.

I understand my personal information is collected, used, and stored in a professional manner according to PIPEDA/PHIPA standards and Fit Smile Dental Hygiene privacy policy. My dental hygiene services are rendered according to the standards of infection control mandated by the CDHO. I understand that payment is due in full after treatment is rendered (unless prior arrangements have been approved). I give consent for dental hygiene treatment on my behalf (or my dependent) and understand that the specific risks, benefits, and post care instructions will be provided by the dental hygienist during relevant course of the appointment. Additional written informed consent may be required for complicated or special procedures.

I understand that any questions I may have regarding any treatment should be brought forth to be answered and addressed by the dental hygienist.

○ Yes, I consent.	○ No, I consent
Patient/Parent/Guardian Signature:	Date: