Midway Dental Center

DR. JAMES L. STRAWN, D.D.S.

CONSENT FOR TREATMENT AND RELEASE

Due to the fact that dentistry is not an exact science, I acknowledge that Dr. Strawn and the staff of Midway Dental Center cannot make any guarantees or assurances concerning the outcome of my treatment. I understand that any treatment and the fees involved will be explained to me before it is begun and any questions I have will be answered.

I authorized my doctor to release my medical records, including, but not limited to, radiographs (xrays), reports, charts, medical history, photographs, findings, plaster models or impressions of teeth, prescriptions, diagnosis, medical testing, test results, billing and other treatment records in my doctor's possession (Medical Records) (i) to other licensed dentists, physicians, or laboratories, their representatives, employees, successors, assigns, and agents for the purposes of investigating and reviewing my medical history as it pertains to my continued treatment.

I understand that use of my Medical Records may result in disclosure of my "individually identifiable health information" as defined by the health insurance Portability and Accountability Act "HIPPA". I hereby consent to the disclosure as set forth above. I will not, nor shall anyone on my behalf seek legal, equitable or monetary damages or remedies for such disclosure. I acknowledge that use of my Medical Records is without compensation and that I will not nor shall anyone on my behalf have any right of approval, claim of compensation, or seek or obtain legal, equitable or monetary damages or remedies arising out of any use such that comply with the terms of this consent.

A photo static copy of this consent shall be considered as effective and valid as an original. I have read, understand and agree to the terms set forth in this consent as indicated by my signature below.

ARBITRATION AGREEMENT

Our constant goal is to meet our patient's expectations for treatment. If, however, in the rare instance that a misunderstanding arises, our office will make every effort to resolve it with you. If that fails, you have the option of filing a claim with a professional mediator or arbitrator.

The cost of this can be several hundred dollars, split 50/50 with this office. By signing below, you agree that any un-resolved dispute about the reasonableness or computation of the fees, or any claims of negligent or intentional acts or omissions in the rendering of professional services rendered by the doctor or staff in this office, shall be submitted for binding arbitration to the American Arbitration Association or similar organization.

It is understood by both doctor and patient that by agreeing to submit all claims or assertions that either the patient (responsible party) or the doctor may have against the other arising out of this agreement, patient and doctor have given up their right to a jury or court trial.

SIGNATURE_____ PRINT NAME_____

SIGNATURE_____ PRINT NAME_____
(If signatory is under 18, the parent, or Legal Guardian must also sign to signify agreement)

WITNESS_____ DATE_____