Virtudent

GENERAL CONSENT FORM

CONSENT TO TREATMENT

I do hereby voluntarily consent to treatment by the hygienists/dentists of Virtudent MA, P.C., d/b/a Virtudent (the "Practice") for a dental screening and preventative dental treatment, including a professional dental cleaning and x-rays and to any related diagnostic procedures and treatments as necessary in the judgment of the hygienists/dentists of the Practice, which may include dental sealants and fluoride varnish application. I understand that the Practice is providing me preventative dental care and a telehealth dental screening, which is not a substitute for a comprehensive dental examination by a dentist. I specifically consent to the taking or use of photographs/radiographs and the transmission of these images to provide telehealth dental screening services.

USE AND DISCLOSURE OF MY GENERAL HEALTH INFORMATION:

I understand that the Practice may use and disclose my medical information so that it may treat me, seek payment from third parties for such treatment, and generally carry on the health care operations of the Practice (*e.g.,* quality assurance). I authorize the Practice to communicate with me through the Practice's secure web platform.

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I understand that it is my responsibility to supply the Practice with current insurance information and/or any referral authorization forms that may be necessary for my insurance. I am aware that if I am referred to a dentist for additional care and that dentist takes additional/duplicate diagnostics that my insurance may not cover those charges. I understand that insurance companies require members to pay deductibles, co-payments, and any non-covered services at the time services are rendered.

I am aware that I am responsible for any unpaid balances. I authorize the Practice to charge my credit card on file or send an invoice for any outstanding balance. If my account results in collection agency involvement, the undersigned, guarantor receive all payments for services rendered to me or my dependents.

Acknowledged and Agreed: By clicking here, I accept the terms and conditions of this Agreement and confirm that my electronic acceptance of this Agreement is the legally binding equivalent to my handwritten signature.

If the patient is a minor or not legally capable of consent, please print this form and sign below.

Signature of Authorized Representative	**Authority/Relationship to Patient**	**Date**