Notification of Health Care Services Provided without Compensation and Limitation of Dentist/Dental Hygienist Liability

Patient Name (Print) _____

Dentist/Dental Hygienist Name (Print) _____

Check one:

☐ I am the patient

-OR-

☐ I am a person who has legal authority to make health care decisions for the patient.

Authorized Representative Name (Print) _____

My dentist/dental hygienist is providing me with dental care services free of charge. However, I may be required to pay my dentist/dental hygienist for materials, laboratory fees, or other out-of-pocket expenses. In cases where my dentist/dental hygienist is providing the services at a dental clinic, I may also be required to pay the clinic fee for my dentist/dental hygienist's services. However, my dentist/dental hygienist will not be paid for providing these services.

By signing this notification form, I understand and agree that my dentist/dental hygienist is not liable for any injury, death, or other loss arising out of these dental care services unless the injury, death, or other loss is caused by my dentist/dental hygienist's gross negligence.

I received and am signing this notification before receiving any dental care services. Additionally, I have given my informed consent to receiving these dental care services from my dentist/dental hygienist.

_____ _____

Patient's Signature *Date*

-OR-

_____ _____

Signature of Patient's authorized representative *Date*

Form Oct. 2012