

Volunteer For Dental

31 East Clay Avenue | Muskegon, MI | 49442 | 231.773.1360

2025 Participant/Volunteer Agreement

Every participant is required to complete this agreement once per year in order to receive services through the Volunteer For Dental program.

PLEASE PUT YOUR INITIALS ON THE LINE IN FRONT OF EACH STATEMENT INDICATING THAT YOU AGREE TO EACH STATEMENT:

_____ I agree that I will **NOT** go to the hospital emergency department for a tooth problem once I have started this program.

_____ I understand that I have the responsibility to treat **everyone** with courtesy and respect. *If I fail to treat someone with courtesy and respect, I will be dismissed from the program.*

_____ I understand that **donated services and appointments are limited**. I cannot demand specific treatment or appointment times from anyone.

_____ I understand that the dentists are providing my care free of charge because I have said (and provided documentation to show) that I **cannot afford this treatment**. If my words or actions prove otherwise I will be dismissed from the program.

_____ I understand that I **must provide my volunteer hours in writing** on the program tracking form or the volunteer organization letterhead before I can receive treatment.

_____ I understand that **only dental appointments scheduled by the VFD staff** will be covered by this program. If I schedule my own appointment then I will have to pay for the dental services provided at that appointment.

_____ I understand that I will have to pay **\$35 for a missed appointment** or an appointment cancelled without **2 business days' notice** and after a second missed appointment I will be dismissed from the program.

_____ I understand that there is a **\$2000 maximum treatment value per year** in this program.

_____ I understand that I **am a patient of Volunteer For Dental** and am not a patient of record at any dental office that I may receive treatment from.

_____ I understand that I **am to say "thank you"** to those who provide my dental care and **send them a thank you card**.

_____ I understand that I **must keep my teeth and gums clean and healthy**. A provider may decline to provide me dental care if my teeth or gums are not being properly cared for.

OVER→

Consent for Treatment and HIPAA Agreement

_____ I consent to the dental treatment I need as diagnosed by a volunteer dentist for the Volunteer For Dental program. I may ask questions before treatment is started of the dentist or their staff to be sure I understand exactly what a procedure is and involves if it is not clear to me. I will be provided a list of all intended treatment by Volunteer For Dental and may ask questions of their staff as well.

_____ I authorize Volunteer For Dental to release any of my information to participating dental providers and any other necessary providers of services in order to help me. I understand that my protected health information will be used for this purpose only. The VFD HIPAA privacy policy will be made available to me upon my request.

Photo and Video Release

I, _____ (please print your name), grant permission to Volunteer For Dental and its agents and employees the **irrevocable and unrestricted right to reproduce the photographs and/or video (including my voice) taken of me** for the purpose of publication, promotion, illustration, or advertising in any manner or in any medium. I hereby release Volunteer For Dental Care and its legal representatives for all claims and liability relating to said images or video. Furthermore, I grant permission to use my statements that were given during an interview on video or in writing, with or without my name, for the purpose of advertising and publicity without restriction.

Signature _____ Date: _____

Limitation of Liability

The dental care offered by Volunteer For Dental is FREE and compensation for the dental care will not be requested from any source. Under Michigan law, because the dental care is free (and based on other conditions), the person(s) who provide the dental care will not be liable in civil action for damages for acts of omissions in providing dental care, unless the acts or omissions were the result of gross negligence or willful and wanton misconduct, or were intended to injure the patient.

By signing this form, I acknowledge the following:

1. I am the patient or a legal representative of the patient
2. I have received a copy of the notice of limitation of liability
3. I signed this notice before the dental care was provided

I am joining this program of my own free will and personal decision. I have read, understand and accept each area of this agreement; I will abide by all rules and standards to be eligible for assistance in the Volunteer For Dental program.

Participant/Volunteer Signature

Date