

### **Consent for Services**

I hereby give consent for the doctors and staff to perform such diagnostic, photographic, and therapeutic procedures as may be necessary on me and/or my child(ren). This practice depends upon the reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient can be determined before treatment. If patient does not carry insurance, payment is due in full for services rendered. Patients who carry dental insurance understand that all dental services furnished are charged directly to your insurance company. Your insurance policy may or may not follow the American Academy of Dentistry Guidelines. **IT IS YOUR RESPONSIBILITY TO KNOW YOUR OWN COVERAGE.** If you do not want us to provide the recommended standard of care for you or your child(ren), it is your responsibility to notify us.

As a courtesy, we will help prepare patients' insurance form and file the claim. Insurance companies **DO NOT GUARANTEE** any payment until they receive the claim, review it and process it according to the specific policy terms. We will assist patients in making collections from insurance companies and will credit any such collections to patient's account. If there is a balance after the insurance payment is received, a bill will be immediately sent to you for payment. Payment is due within 30 days of statement. However, this dental office cannot render services on the assumption that the charges will be paid by your insurance company.

Any account that still has a balance after 30 days will receive a follow-up call from our staff. This office can process credit card payments over the phone to clear up the account balance. Once attempts have been made by phone/mail and there is no response to courtesy calls/mail, the account balance may/may not be sent to 3rd party collections agency "Transworld". You will be responsible for any costs incurred to collect including but not limited to, collection agency fees, attorney fees and court costs.

**24 hour notice** is required to cancel appointments. Missed appointments or same day cancellations will be assessed a \$50 fee, payable immediately.

I grant my permission to you or your assignee to telephone me at work, home and cell to discuss matters related to this form.

I have read the above condition of treatment and payments and agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian      Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### **Notice of Privacy Practices**

#### **Our Legal Duty:**

We are required by applicable federal and state law to maintain the privacy of your health information and give you notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2015, and will remain in effect until we replace it.

We reserve the right to make changes in our privacy practices Notice and new terms for all health information that we maintain, create or receive prior to the changes. Changes to PPN will be made anytime where permitted by applicable law.

#### Uses and Disclosure of Health Information:

Treatments, Payments, Health Operations, Your Authorization, To your family, Persons involved in your care, Abuse or Neglect, Required by Law, National Security, Appointment Reminders.

#### **Acknowledgement to Receipt of Office Privacy Policy**

I, \_\_\_\_\_, have reviewed this Notice of Privacy Practices.

\_\_\_\_\_  
Signature of patient, parent or guardian      Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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**For Office Use Only:** We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign       Communication barriers prohibited obtaining the acknowledgement  
 An emergency situation prevented us from obtaining acknowledgement       Other \_\_\_\_\_

**HIPPA AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION**

I, \_\_\_\_\_, authorize the dental office named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, substance abuse treatment, and mental health services] under the following terms and conditions:

1. A detailed description of the information to be released: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. To whom the information can be released to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual)  
\_\_\_\_\_  
\_\_\_\_\_

4. Expiration date: \_\_\_\_\_

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it anytime except when we have already acted in reliance upon the authorization. To revoke your authorization, send in a written or electronic requested. When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility. ***I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.***

Dated: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

**If you are signing as a personal representative of the patient please sign below:**

Relationship to Patient: \_\_\_\_\_ Print Name: \_\_\_\_\_

Source of Authority: \_\_\_\_\_

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**For Office Use Only:** We attempted to obtain written acknowledgement of receipt of HIPPA AUTHORIZATION, but acknowledgement could not be obtained because:

- Individual refused to sign                       Communication barriers prohibited obtaining the acknowledgement  
 An emergency situation prevented us from obtaining acknowledgement     Other \_\_\_\_\_