Drs. Perkins & George, DDS.
13321 New Hampshire Ave. Suite 102 | Silver Spring, MD 20904
P: 301-989-3400 | ***F:*** 301-989-1707 | ***E:*** colesvilledentalxrays@gmail.com

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 a 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 forms 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 the 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 statement in the mail and possibly a follow-up call/text from our staff. This office can process credit card payments over the phone to clear up the account balance. This office reserves the right to apply a late fee, interest charge or finance fee to any patient account if the balance is 60 days or more past due. Once attempts have been made by phone/mail unsuccessfully, the account balance may 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 minimum $50 Failed Appointment fee but the fee can increase depending on the type of appointment that was scheduled and the length of time reserved for the appointment, 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.

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

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

,_____, have reviewed this Notice of Privacy Practices.

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

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_____

Drs. Perkins & George, DDS.
13321 New Hampshire Ave. Suite 102 | Silver Spring, MD 20904
P: 301-989-3400 | ***F:*** 301-989-1707 | ***E:*** colesvilledentalxrays@gmail.com

HIPAA 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:_____
_____
_____

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 request. 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:_____

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_____