PRIVACY NOTICE:

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of our practice.

I have been informed of, and given the right to review and secure a copy of our Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Initials:_____

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for the delivery of proper dental care.
- I authorize release of any information concerning my (or my child's) healthcare, for the advice and treatment provided for purpose of evaluation and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) healthcare, for the advice and treatment to another dentist, or another healthcare professional and their staff.

Initials:_____

OVER

FINANCIAL RESPONSIBILITY

- I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me. If my insurance company does not respond with payment within 30 days from the date of filing the claim, I understand that I am responsible for the full amount of charges.
- I understand that as a courtesy, my dentist and staff will estimate insurance benefits as accurately as possible and submit claims on my behalf. I understand that I am responsible for any portion not covered by my insurance and for providing correct insurance information.
- I understand that if insurance is not applicable when dental services are rendered, then full payment is due at the time of service.
- I understand that I may be charged a fee of $50 for cancellations made less than 48 hours in advance.
- Returned checks and balances older than 60 days will be subject to finance charges. Accounts unpaid after 90 days will be subject to collections and any fees necessary in collecting the balance of the account will be your responsibility as well.

Initials:_____

DO WE HAVE PERMISSION TO DO THE FOLLOWING?

Leave a reminder regarding your appointment via voicemail, text and/or email? **Y / N**

Speak to other members of your household regarding your appointment? **Y / N**

Discuss your dental treatment with any members of your household? **Y / N**

Leave a message at you place of employment? **Y / N**

If yes to any of the above, whom?_____

Relationship:_____

Signature:_____ Date: _____