Notice of Privacy Policies

Last Name: First Name: Birthdate:

Date:

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 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or 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 your practice.

I have been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested rertrictions. However, if you do agree, you are bound to comply with this restriction.

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.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
- I authorize the dentist to perform diagnostic procedures and treatment as necessary for the delivery of proper dental care.
-I authorize the 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.

FINANCIAL RESPONSIBILITY
- I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.
-I understand that my dentist and staff will estimate insurance benefits as close as possible. I understand that I am responsible for payment of the account, and 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.

DO WE HAVE PERMISSION FOR THE FOLLOWING:

-Leave a reminder regarding your appointment on your voicemail? Y / N

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

-Leave a message at your place of employment? Y / N

If yes to any of the above, whom?_____

Relationshiip:_____

_____ _____

Signature Date