Patient Consent (HIPAA)

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 payer (i.e. my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of, and give 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 restrictions. However, if you do agree, you are then 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.

Signed this _____ day of _____________ 20___.

Print Patient Name: ____

Relationship to Patient: ____

Signature of Patient or Guardian: __________________________________

Acknowledgement of Financial Responsibility

Payment is due on the day a service is provided. As a courtesy to our patients, we submit claims to the insurance that you provide to us, given that it is an insurance that this office participates in. As a patient, it is your responsibility to understand your insurance plan benefits. Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges.

An example of an instance where your insurance may not cover their estimated portion of a procedure would be having a tooth colored composite filling done, whereas your plan only pays for "silver" amalgam fillings, or having a crown placed that is made of a more suitable material than a base metal.

CANCELLATION POLICY: Confirmed appointments that are failed or cancelled within 24 hours of appointed time will result in a $35 cancellation fee.

____ ____________________

Signature of Patient or Guardian Date