Consent For Treatment

Patient's Name:_____ Date of Birth:_____
Facility or Home Address:_____
Name of Facility:_____
Phone:_____ Contact Name:_____

Physician's Name:_____ Phone:_____ Fax:_____

Dentist's Name:_____ Phone:_____ Fax:_____

Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to maintain the confidentiality of your health information. This describes how we may use and disclose your protected information to carry out treatment, payment of health care operation and for other purposes that we are permitted or required by law. We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. For example: your dental/health information may be provided to a dentist to whom you have been referred. In addition, we may disclose your protected health information periodically to another dentist, physician, or health care provider who becomes involved in your care. We may use and disclose dental information about you in order to obtain payment for services rendered. Such disclosures may be made to you, an insurance company, responsible party or third party. We may also tell your health plan about a treatment you are going to receive to obtain prior to approval or to determine whether your plan will cover treatment.

I give consent for dental hygiene and preventive treatment for the patient.
I have reviewed the Privacy Practices above.
Permission is granted to review Medical Records.
An associate RDHAP may be the provider of services.
Permission is granted to take photos of patient for chart ID and educational purposes.
Full payment is required at the time of service, unless arrangements are made in advance.
A super-bill can be provided for possible insurance reimbursement.

Signature of Responsible Party_____Date_____
Relationship to Patient_____
Phone_____ Fax_____email_____
Mailing/Billing Address_____

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