PATIENT CONSENT FORM

I. RELEASE INFORMATION – I, the below named patient, do hereby authorize the dentist examining and/or treating me to release any third payor (such as an insurance company or governmental agency, Example: Blue Shield of Florida) any medical, dental information and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. DENTAL INSURANCE ASSIGNMENT – I, the below named subscriber, hereby authorize payment directly to my dentist examining or treating me of any group and/or individual dental/medical benefits herein specified and otherwise payable to me for their services as described.

III. I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at the dentists office.

IV. COPIES OF MEDICAL RECORDS – I, the below named patient, am entitled to one copy of the dental record for a reasonable charge.

V. I agree that should the amount of the insurance benefits be insufficient to cover the expenses, I will be responsible for payment of the difference. I will be responsible for the entire amount due for professional services rendered if the expense is not covered by my policy.

VI. I understand that payment for professional services is due when said services are rendered, unless other arrangements are made in advance. I agree to pay all amounts not payable by insurance immediately when billed. All amounts not paid within 30 days will be assessed a monthly finance fee equal to 1.5% of the outstanding balance. If I fail to pay all amount due in a timely manner, I agree to pay all costs incurred for collection, including reasonable attorney's fees, whether a lawsuit is filed or not.

VII. HIPAA – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The privacy rule was also created in order to provide standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as Laboratories that only interact with dentists and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care options. These entities are most often not required to obtain patient consent.

You may refuse to consent to use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA compliance officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

WOULD YOU LIKE A COPY OF THIS FORM? _____yes _____no

SIGNATURE_____DATE_____