

Clayton Dentistry

Dennis P. Clayton D.M.D.

General Dentist

PATIENT HIPAA CONSENT FORM

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 also 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 restrictions.

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.

I give my consent to send a recall postcard. I give my consent to leave a pre-medicate reminder and/or confirmation message on my answering machine.

Name (PRINTED): _____

Name (SIGNED): _____ DATE: _____
Parent or Guardian if minor

I also give permission to the following person(s) as noted to discuss my treatment and/or account information with your office:

* _____ Relationship to patient _____

* _____ Relationship to patient _____

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FINANCIAL POLICIES & CONSENT FORM

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. As a condition of your treatment by this office, financial arrangements must be made in advance. Payment in full of the estimated patient portion of the fees is due when services are rendered.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

We may submit a predetermination of benefits for your treatment; but please understand that a predetermination is not a guarantee of coverage or payment. If you elect to proceed with treatment without a predetermination, your copay is only an estimate and not a guarantee of payment. The estimate we provide to you will be obtained from information given to us by your insurance carrier.

If your pre-treatment estimate is rejected for any reason as stated by your insurance company, the balance will be your responsibility. Your pre-treatment estimate may change because your provider may perform and bill for additional services that are not included in the initial estimate, the nature of your procedure may change while in progress, or changes in industry standards that determine the prices of certain services may result in a change in cost.

We ask that any balance be paid upon receipt of your billing statement.

I grant my permission to you or your assignee, to telephone me at home, on my cell phone, or at my work to discuss matters related to this form.

I hereby authorize payment of insurance benefits directly to the dentist or dental group. I understand that my dental care insurance carrier or payer of my dental benefits **may pay less** than the actual bill for services. I understand **I am financially responsible** for payments in full of all accounts.

By signing this form, I acknowledge I have read and accepted these terms and agree to be financially responsible for any difference in the amount owed, in addition to any determined copays and/or deductibles.

I have read the above conditions of treatment and payment and agree to their content.

Name (PRINTED): _____

Name (SIGNED): _____ DATE: _____

Parent or Guardian if minor