

TO THE PATIENT: PLEASE COMPLETELY FILL OUT SECTIONS 1, 2 & 3, SIGN AND DATE WHERE INDICATED.

Patient Information

SECTION 1

Date: _____

Name: _____ Married Single Minor Male Female
Last First M

Birth Date: ____/____/____ SS# ____-____-____ Drivers License Number: _____

Address: _____
Street Apt # City State Zip

E-Mail Address _____ Phone – Home: _____

Phone – Work: _____ Ext. _____ Time to Call: _____ Cell: _____

Place of Employment _____ Occupation/Position _____

If Full time Student, School Name: _____ Grade _____

Medical Insurance Company: _____ ID# _____ Group # _____

Dental Insurance Company: _____ ID# _____ Group # _____

Has any member of your family been treated in our office? Yes No Local # _____

Whom may we thank for referring you to our office? How did you Hear about it? _____

Insured Information

IF THE PRIMARY SUBSCRIBER IS SOMEONE OTHER THEN YOURSELF

Father **Husband**

Last First M

Street City State Zip

Home # Work #

Birth Date (Mo/Day/Year) SS#

Employer Drivers License #

Dental Insurance Co. Group #

Mother **Wife**

Last First M

Street City State Zip

Home # Work #

Birth Date (Mo/Day/Year) SS#

Employer Drivers License #

Dental Insurance Co. Group #

Emergency Information

Name _____
 Address _____
 City/State/ZIP _____
 Telephone # _____
 Relationship _____

Responsible Party

Responsible party currently is a patient of record at this office Yes No

Method of Payment:

Patients will be expected to pay for services when treatment is rendered.

Visa/MasterCard are accepted.

I wish to discuss interest free financing with Care Credit

If you have insurance, we will help you to determine the coverage you have available. We ask that you assign your insurance benefits to us. Professional care is provided **to you, our patient, and not to an insurance company**. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We will help in every way we can in filing your claim and in handling insurance questions from our office on your behalf. However, insurance balances 60 days and over are **due in full from the patient**.

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I realize a responsible adult (parent or guardian) must remain in the office while treating a minor.

Initials: _____

Date: _____

Adult Patient Father Husband Mother Wife Guardian

PLEASE PRINT YOUR NAME _____

SECTION 2

Medical History

Yes No

Are you under a physician's care now? Why? Who? _____

Date of last physical exam _____

Have you ever been hospitalized or had an operation? Describe _____

Have you ever had a serious injury to your head or neck? Describe _____

Are you taking any medications, pills or drugs? (Include illegal/recreational drugs) What? _____

Are you on a special diet? Describe _____

Are you allergic to any medications or substances? Please check box for allergic reaction below _____

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other _____

Women (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives

Describe _____

Do you have or have you ever had any of the following:

(*If yes to any of the * starred conditions, please call prior to your appointment...premedicatons may be required)

	Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur*	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia (Bleeding Problems)	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse*	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve*	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker*	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery*	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A & C (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (Serum)	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Use/Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
						Seizure	<input type="checkbox"/>	<input type="checkbox"/>
						Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
						Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
						Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
						Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
						Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
						Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>
						Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
						Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>
						Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>
						Artificial Joints*	<input type="checkbox"/>	<input type="checkbox"/>
						Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
						AIDS*	<input type="checkbox"/>	<input type="checkbox"/>
						HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
						Herpes (Cold Sore)	<input type="checkbox"/>	<input type="checkbox"/>
						Drug Addiction/Use	<input type="checkbox"/>	<input type="checkbox"/>
						Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>
						Snoring / Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had any other serious illness not checked above? Describe _____

Do you wish to talk to the dentist privately about any problem? _____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail I will inform the doctor promptly of any medications legal or illegal, prescription or non-prescription that I am taking.

In Accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a NOTICE that describes how medical information about you may be used and disclosed and how you can get access to this information is posted in the RECEPTION room. Should I desire to have a printed copy of this NOTICE, I will check the following box and notify the RECEPTIONIST: **I DO WANT A COPY OF 'NOTICE'** **I DO NOT WANT A COPY OF 'NOTICE'**

SIGN: _____

Date: _____

Adult Patient Father Husband Mother Wife Guardian

Reviewed by Doctor _____ Date _____ BP _____

History review and significant findings: _____

Medical History Update

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 3

Dental History (Patient To Fill Out Completely)

Primary reason for this dental appointment: Examination Emergency Consultation

Date of your last dental visit _____ For what? _____

Date of your last dental cleaning _____ **Yes No**

Do you have a specific dental problem? Describe _____

What kind of dental procedures have you had done in the past? _____

Do you have any sensitive teeth? _____

Have you ever had a toothache or a fractured tooth? _____

Have you ever had periodontal problems? _____

Do you like your smile? Why? _____

Does food catch between your teeth or do you have areas that are difficult to floss? _____

Does loss of teeth tend to run in your family? _____

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____

Have you ever had Orthodontics (Braces)? _____

Have your past experiences in a dental office always been positive? _____

Do you smoke or chew tobacco? Any sores or growths in your mouth? Describe _____

Name of previous dentist (Optional) _____

Why did you leave your last dentist? _____

Have you noticed spots or stains on your teeth that concern you? _____

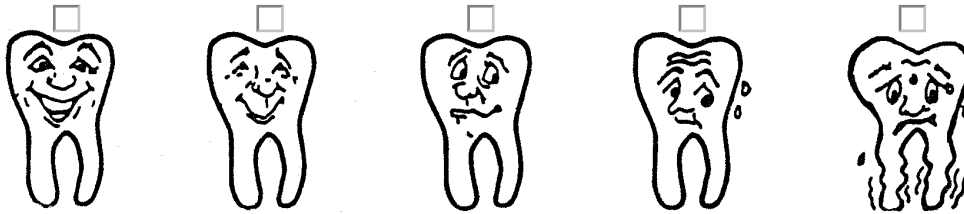
Anything else that concerns you about the appearance of your teeth? _____

If you could change anything about your smile, what would you change? _____

Do you have a denture or partial denture? No Yes How old are they? _____ How do you like them? _____

Have you ever required Nitrous Oxide (Laughing Gas) or sedatives for your dental treatment? _____

Check Your Level of Bravery: Don't Worry, We Cater To Cowards



SECTION 4

Initial Clinical Exam (I.C.E.)

Date: _____ Patient Name: _____

Blood Pressure: _____ :

Stains: No Lt Mod Hvy TMJ: Asymptomatic Symptoms: _____

Calculus: No Lt Mod Hvy Homecare: Brushing: _____ x/day Floss: _____ x/week

Plaque: No Lt Mod Hvy Perio Diag: Normal Gingivitis Early Perio Mod Perio Adv Perio Maint

Bleeding: No Lt Mod Hvy Instructions: Brush Floss Perio Aid Other: _____

Ortho: Occlusal Type: CLI CLII CL III

Soft Tissue Screening

Cancer Exam: Normal Lesion: Describe _____

Normal Abnormal

See dental history for smoking history

Lips	<input type="checkbox"/>	<input type="checkbox"/>
Mucosa	<input type="checkbox"/>	<input type="checkbox"/>
Palate	<input type="checkbox"/>	<input type="checkbox"/>
Tongue	<input type="checkbox"/>	<input type="checkbox"/>
Floor	<input type="checkbox"/>	<input type="checkbox"/>
Glands	<input type="checkbox"/>	<input type="checkbox"/>
Pharynx	<input type="checkbox"/>	<input type="checkbox"/>

Upper Right	Upper Anterior	Upper Left
Lower Right	Lower Anterior	Lower Left

Maximum Pocket Depth
Per Sextant in mm

Recall: _____ Months Doctor's Signature: Reviewed by: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect June 22, 2009, and will remain in effect until we replace it.

We may change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We may make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. We will post a copy of our notice in our office and on our website www.dentalworks.com. The effective date of the Notice is provided above.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact the Privacy Officer whose contact information is provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to another dentist or healthcare provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, and licensing or credentialing activities.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state worker's compensation laws.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

Your Authorization: As explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures already made with your authorization while it was in effect.

PATIENT RIGHTS

Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Right to Accounting of Disclosures of Your Health Information: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, and healthcare operations, and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a fee for responding to these additional requests. You must submit a written request that is signed and dated. Your request must be submitted to the Privacy Officer, 5875 Landerbrook Drive, Suite 250, Mayfield Heights, OH 44124.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer, 5875 Landerbrook Drive, Suite 250, Mayfield Heights, OH 44124. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request. Your request must be submitted to the Privacy Officer, 5875 Landerbrook Drive, Suite 250, Mayfield Heights, OH 44124.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended. Your request must be submitted to the Privacy Officer, 5875 Landerbrook Drive, Suite 250, Mayfield Heights, OH 44124. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

Right to Written Notice: If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PRIVACY OFFICER

Should you wish to contact the Privacy Officer, you may do so at the address and telephone number below.

Privacy Officer
5875 Landerbrook Drive, Suite 250
Mayfield Heights, OH 44124
Telephone: (440) 684-6940

MSD Dental Financial Policy & Consent for Services

Welcome to our office. We are dedicated to providing you with the very best dental care and services, as a result, your understanding of our financial policy is an essential element of your care and treatment. To assist you, we have the following financial policy. Please read it thoroughly. If you have any questions, please feel free to discuss them with our office staff.

-Dental Insurance Policy- Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. We are happy to submit the claims necessary to see that you receive the full benefits of your coverage; however, we cannot guarantee any estimated coverage. You, the financially responsible party, agree that should your insurance company fail to pay any portion of the claim(s) due to frequency limitations, exclusions, maximums, deductibles, age limitations, waiting periods, eligibility, termination or any other reason not listed you are 100% financially responsible for all fees not covered or paid by your plan. Benefits and eligibility are verified upon request from the patient. It is patient responsibility to provide us with accurate insurance benefit details including a copy of the insurance card if applicable, subscriber ID, birthdates, and any other information pertaining to acquiring insurance benefits. Insurance carriers only provide a Summary of dental benefits and not a guarantee of payment. This office cannot render services on the assumption that our charges will be paid by your dental insurance. If something is not covered on your insurance plan, it does not mean it was not necessary, it simply means it may NOT be a covered benefit on your particular dental plan. For benefit details about your plan please call your dental insurance company directly for the most accurate information. I understand that Dental Insurance carriers cannot and do not diagnose treatment. The goal of dental insurance is to pay for the least expensive option for dental treatment not the best option for your health. Insurance carriers may downgrade their payments for procedures. Pre-Authorizations are NOT a guarantee of payment.

-Payment/Patient Portion is due when services are rendered unless a prior payment arrangement has been made: For your convenience, we accept Visa, MasterCard, Discover, and American Express credit cards; we also accept cash and check payments. Outside financing is available through Care Credit with interest free payment options (6 mo. for under \$1000, and 12 mo. for over \$1000 (Care credit cannot be combined with Promotional offers).

-Deposit Policy- Due to the extensive amount of time our staff and doctors devote to preparing for your appointment **We do require a deposit to reserve your time with the doctor for major dental work** .In the event you cancel, reschedule or no show with **less than 2 business days'** notice, you will forfeit your deposit and be required to pay a new deposit upon rescheduling

-Reschedule/ Change in Schedule Policy- Our practice is dedicated to quality care and exceptional service. Our doctors and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other clients. If you find that you must change your appointment, we require a minimum of 48 hours-notice so that we may make every effort to accommodate other clients. If proper notice is not received, a fee of \$50.00 will be charged for every hour of allotted time cancelled

-In the event your account balance is 30 days past due, a \$20 per month late fee will be charged to your account and will be sent to collections after 90 days. A \$50 fee for cancelled/returned checks will also be added to your account.

-There is a fee to copy/e-mail patient records, unless we are copying them for a specialist referral we have arranged. They require a release form signed and may take 5-10 business days to process.

-Minors- Separated or divorced parents of minors, who are responsible for one half of the cost of a child/children dental care: The parent who brings the child in to the dental appointment is responsible for paying the co-payment or full fee. If it is necessary, we are happy to hold a credit/debit number from the non-custodial parent on file.

Consent for Services & Standard of Care

Standard of care is a legal concept that a dentist must meet and is the basic practices of highly regarded dentists who have comparable education and knowledge, who practice in similar disciplines and those who practice in a comparable area. The standard simply reflects that which is minimally required, meaning that anything less would be considered negligent.

Standard of care for our office is as follows:

- **The doctor and hygienist recommend regular cleanings a minimum of 1 time every 6 months, regardless of insurance coverage. The type of cleaning is determined by the health of your teeth and gums not by your insurance.**
- **Fluoride Varnish to protect my teeth from cavities- min. 2 times a year and may not be covered by insurance**
- **Periodontal maintenance cleanings 1 time every 3-4 months with irrigation which may not be covered by insurance**
- **Doctor/Dentist requires x-rays be taken in order to be able to diagnose accurately.**
- **Dental X-rays are a very important diagnostic tool- We require at a minimum Full mouth x-rays are taken every 3 years, check-up x-rays are taken annually. We will accept digital x-rays from another office as long as they are less than 3 mo. old from the date taken • Emergency/Limited Exam/Dental Treatment x-rays are taken as needed.**

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor. I give consent to the doctor or designated staffs use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for purpose of carrying out my treatment, payment and health care operations to make a thorough diagnosis of myself or my dependents dental needs. I grant my permission to you or your assignee, to telephone, text, e-mail me at home or at my work to discuss matters related to my dental health as well as to receive appointment reminders and confirmations. I understand that dentistry is an inexact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment(s) which I have requested and authorized.

I, (please print) _____, have read and understand the Consent for Services for MSD.

Signed: _____ Date: _____

Relationship to patient

updated 06032019

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient’s rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____