CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

To the Patient: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices ***(additional copies available upon request)*** before you decide to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices to follow federal/state guidelines.

Right to revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this consent may involve that we decline to treat you or to continue treatment. You have the right to refuse this disclosure only if there is no need to bill third parties and services are paid in full.

I (print name of patient/guardian), _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving consent to use and disclose of my protected health information to carry out treatments and payment activities.

Signature of Patient/Guardian:_____ Date:_____

SMITH FAMILY DENTAL

DENTAL INSURANCE

There are over 3,000 different types of dental insurance plans. We do our best to help you understand and work with your insurance policy, find out the allowed maximum, any deductibles and eligibility services. At Smith Family Dental, we gladly submit your insurance claims for you and will fully attempt to help you receive full insurance benefits. However, you are **ultimately,** responsible for payment of the services provided. Please remember that an insurance policy is a contract between you, and your employer and the insurance company, and we have no direct relationship with them.

Because policies can change every year when contracts renew, often without clear communications, we encourage our patients to become familiar with their insurance coverage. We also recommend that our patients take the time to understand which policy they are selecting during open enrollment period. Changes in eligibility, maximums, or benefits could result in unexpected out of pocket cost. Ultimately, all charges for services are your financial responsibility, especially if your insurance denies treatment coverage.

CONSENT FOR TREATMENT

I hereby authorize Smith Family Dental (SFD) to take X rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental health needs. I also authorize SFD to perform all recommended treatment and to administer the appropriate medications and/or anesthetics **mutually agreed upon**. I understand that using anesthetic agents is optional and using them involves certain risks, such as, but not limited to, hematoma, parasthesia, trismus, or increased heart rate. I will be given an opportunity to discuss any concerns or questions that I may have.

Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges in this office. All charges will be paid at the time of service unless written financial agreements were made in advance. I understand that this office cannot guarantee coverage from insurance companies therefore I will be fully liable for all treatment rendered. I agree to pay all late fees ($25.00 if balance not paid in 30 days), collection costs (40%), attorney fees, and any other costs that may be incurred to enforce collections of any outstanding amount. We reserve appointments especially for you, if you are unable to keep your scheduled appointment please inform us within 24 business hours or there will be a $35.00 fee with the exception of emergencies. In the event you choose not to show, there will be a $50.00 fee applied per hour of scheduled time. We accept VISA, MasterCard, DISCOVER, Care Credit and Lending Club. ***Financing options are always available.***

Signature: _____ Date: _____