www.DesertHillsDental.com

PATIENT CONSENT FORM

Federal Law requires us to have you sign this 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 or my minor child(ren)'s treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of this dental 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. (This is posted near the reception area and available at the front desk per your request). 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. However, if you do agree, you are then bound to comply with this restriction.

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.

Signed this ____________________ day of ____________________, 20______________.

Signature: X____

Printed Name:____

Also signed for the following minor child:

Printed Name(s):____

Signature: X____

Your Relationship to patient(s)____

Please be assured our office is compliant and doing everything possible to protect your private health care information.

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REFERRAL INFORMATION

Whom may we thank for referring you to our practice?

❑ Another Patient ❑ Another Dental Office ❑ Employer/Insurance Company ❑ Yellow Pages

❑ Desert Hills Dental Care Staff Member ❑ Desert Hills Dental Care Website ❑ Newspaper

❑ Other ______________________________

Name of Person or Office Referring You to our Practice: ______________________________

CONSENT FOR SERVICES

To the best of my knowledge, all the preceding answers and information are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

Payment of services is due at the time of treatment. Any financial arrangements must be made in advance. A late charge of $10.00 per month will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. Returned checks may be subject to a $25.00 returned check fee. For those patients with insurance coverage: There are thousands of insurance carriers, each having from one to several major policies in existence. You will find these policies in your dental benefits manual. This office cannot render services on the assumption that your charges will be paid by an insurance company, however we do our best to estimate what your insurance will cover on all procedures.

I hereby authorize the release of any information necessary to process my insurance claim. Any payment of insurance benefits otherwise payable to me are to be made to: Desert Hills Dental Care.

A copy of this signature is as good as the original.

I understand that there may be risks associated with dental care, including but not limited to, discomfort, swelling, nerve injury, bruising and/or numbness. I will inform the doctor or staff of the use of recreational or illegal substances, as this can complicate procedures and be life-threatening.

I understand that I am ultimately responsible for payment of services rendered.

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

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

______________________________ Date: ______________

Signature of patient, parent or guardian

Relationship to Patient: ______________________________