

# HENAGAN TEAM DENTISTRY

## CONSENT FOR TREATMENT/HIPPA

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make thorough diagnosis of the patient's dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I understand that photographs may be taken to make decisions on dental treatment. These may be posted within our office and/or practice website for the purpose of showing the progression or completion of treatment. ***If I choose not to have these photographs published I understand that I must make this known to the office staff.***

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I also understand that if I am covered by insurance, my insurance will be filed for me, and assignment accepted as a benefit to me, but I know that insurance benefits are a contract between my insurance company and me. I am ultimately responsible for payment, regardless of coverage.

In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

**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 before you decide whether 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, and of other important matters about your protected health information. A copy of our Notice accomplishes this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described on our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I am aware that because I am 18 years old or older I may elect to authorize the release of my appointment, financial or treatment information to my Responsible Party or Spouse. I DO \_\_\_\_\_ DO NOT \_\_\_\_\_ authorize the release of my appointment, financial or treatment information to my Responsible Party or Spouse.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Responsible Party Signature \_\_\_\_\_ Revocation of HIPPA Consent \_\_\_\_\_