Privacy Practices & Financial Agreement

THIS NOTICE DECRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to maintain the confidentiality of your health information. This describes how we may use and disclose your protected health information to carry out treatment, payment of health care and for other purposes that we are permitted or required by law. We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. For example: your health/dental information may be provided to a dentist to whom you have been referred. In addition, we may disclose your protected health information periodically to another dentist, physician, or health care provider who becomes involved in your care. We may use and disclose dental information about you in order to obtain payment for services rendered. Such disclosures may be made to you, responsible party or third party.

Patient's Name:_____DOB:_____
Name of Care Facility: _____
Facility/Home Address: _____
City: _____ State: _____ Zip: _____
Facility/Home Phone:_____Contact Name:_____

Name of **RESPONSIBLE PARTY**: _____
Relationship to Patient (If other than self):_____
Phone: _____Email: _____
Mailing/**Billing Address**: _____
City: _____ State: _____ Zip: _____

I grant permission for Review of Medical Records.
I grant permission to take my picture for chart ID and educational purposes.
I have had the opportunity to obtain a copy of this form.

All fees are ultimately the responsibility of the **"Responsible Party."**

SIGNATURE OF RESPONSIBLE PARTY: _____
Date: _____