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WELCOME

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I understand that, under the Health Insurance Portability & Accountability Act of 1996, (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this business has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this business at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature. ______________________________

Date: ______________________________

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.

PATIENT'S OR GUARDIAN'S SIGNATURE: ______________________________

DATE: ______________________________