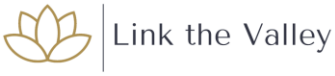

NOTICE OF CONSENT

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)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice.

I have 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. 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 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.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for the delivery of proper dental care.
- I authorize release of any information concerning my (or my child's) healthcare, for the advice and treatment provided for purpose of evaluation and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) healthcare, for the advice and treatment to another dentist, or another healthcare professional and their staff.

FINANCIAL RESPONSIBILITY

- **I hereby authorize payment of insurance benefits directly to the provider. If I get an insurance check in that mail, I will send it directly to the provider.**
- **I understand that I will provide correct insurance information.**

I understand that I will not get a bill from the provider, and they only bill the insurance

DO WE HAVE PERMISSION FOR THE FOLLOWING?

Leave a reminder regarding your appointment on your voice mail? Y / N

Speak to other members of your household regarding your appointment? Y / N

Discuss your dental treatment with any member of your household? Y / N

If yes to any of the above, whom? _____

Relationship: _____

Signature: _____

Date: _____