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Patient Consent 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 Act of 1996 (HIPPA). 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 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 HIPPA. I understand that you have the right to change the terms of this notice form 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 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_____

Patient Name Printed: _____

Relationship to Patient: _____

Signature: _____

Dr. Paul R. Stanovick

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, FINANCIAL POLICIES

- **Consent for treatment**
  I authorize Dr. Paul R. Stanovick to provide dental treatment to myself and or my dependent.

- **Release of Dental Information**
  I authorize Dr. Paul R. Stanovick to release necessary dental information to my insurance company, its agents, or any third-party payor in order for payable benefits for these services to be determined. In order to file insurance, we must have **card holder's social security number and birth date, since we file electronically**, if you do not wish to disclose this information, we do ask that you file your own insurance.

- **Financial Responsibility**
  I understand that Dr. Paul R. Stanovick will file my insurance claims as a courtesy; and accept assignment of benefits if I provide a current copy of my insurance card at each visit, however, I am ultimately responsible for full payment of all charges. My insurance is a contract between myself and my insurance company, Dr. Stanovick's office is not a party to that contract. I also understand that I am responsible for all co-payments and deductibles at the time of my appointment. I further understand my account will be charged a finance charge of 1.5% per month (18% APR) for outstanding balances over 30 days old. If my account is referred to a collection agency or attorney for collection, I agree to pay reasonable collection or attorney's fees of 33 1/3% of the entire balance due and owing plus collection expenses and court costs to the fullest extent allowable by law.

- **Minor Patients**
  The adult accompanying the minor and/or the parents (guardian of minor) are responsible for full payment. For unaccompanied minors, nonemergency treatment will be denied unless previous arrangements have been made through our billing coordinator, by way of check, credit card (Visa or Mastercard), debit card, cash, or money order. INITIAL_____

- **Confirming Appointments**
  We call to confirm your appointments as a courtesy to you. It is important for you to update all phone numbers at each visit. **We reserve the right to fill your appointment if you do not call us back to confirm the appointment.**

- **Missed Appointment**
  We require at least **24 hours notice** if you must cancel an appointment, failure to do so will result in a $51.00 "no show" fee.

- **Returned Checks**
  Our office will charge $30.00 for any check that is returned for insufficient funds.

I have read the above statements and I understand my responsibilities. A copy of this authorization will be considered as valid as the original.

_____ _____

Signature of Patient or Responsible Party Date

*******Please sign HIPPA form on the back of this page. Thank you********