Ashwood Dental

Notice of Privacy Practices

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 have been informed by you of your *Notice of Privacy Practices* containing a more completed description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bounded to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent

Patient Acknowledgment of receipt of Dental Materials Fact Sheet

As of January 1, 2002, the Dental Board of California requires that we distribute to our patients a copy of the Dental Materials Fact Sheet.

I acknowledge I have received from Ashwood Dental a copy of the Dental Materials Fact Sheet for myself and my family member(s) who are patients at this dental office.

Initials: _____

Consent for Treatment

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my 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 give consent to the doctor's or designated staff's use and disclosures of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and healthcare operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

Initials: _____

Financial Policy

- Pay for dentistry as performed. Cash, Check, MasterCard, Visa, Discover, Care Credit.
- All patient co-payments are due at the time of service.
- Please provide insurance information prior to your appointment. We confirm eligibility and bill insurance as a courtesy. We provide co-payment estimates to the best of our abilities. **You are responsible for whatever your insurance does not pay**.
- All patients with an account balance will receive a monthly statement.
- Returned checks will be subject to a **$25.00** service charge.
- We understand your time is valuable, as is ours. In the event you cannot keep your appointment, **48 hours** notice is appreciated or a cancellation fee of **$50.00** may be applied.

_____ _____

Print Name **Signature** **Date**