Consent for Use and Disclosure of Health Information

Patient Name: _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent, Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on the Consent before we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment activities and health care operations. I also acknowledge that I have received a copy of our Notice of Privacy Practices.

Signature: _____

I hereby give permission for my protected health information to be shared with the following person/persons:_____

Signature: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without previous financial arrangements must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. A $30 service charge will be added to all accounts that have a check returned for insufficient funds.

I understand that the fee estimate listed for this dental care can only be extended for a period of 60 days from the date of the patient examination.

I authorize Butler Hill Dental and staff to perform diagnostic services and treatment as may be necessary for dental care of myself or my dependents.

I authorize the release of any information regarding my health history, treatment, or proposed treatment, by butler Hill Dental to another dentist or insurance company. I hereby assign all insurance benefits for which I am entitled, including private insurance and any other dental plan to Butler Hill Dental.

In consideration for the professional services rendered to me, by the doctor, I agree to pay therefore the reasonable value in full of said services to Butler Hill Dental or their assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I agree to pay the actual cost of collections including any court costs and attorney fees if suit is initiated or a collection agency be utilized. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

_____ _____ _____

Signature of patient or guardian **Date** **Relationship to patient**