



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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.

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 by contacting:

Children's Dentistry of Camp Creek
3890 Redwine Road, Suite 206
Atlanta, Georgia 30331

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 the revocation of this Consent will not affect any action 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.

SIGNATURE:

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.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

TRUTH IN LENDING STATEMENT

It is customary to take care of the fee at the time service is rendered, unless other arrangements have been made. We accept VISA, MASTERCARD and DISCOVER. On reconstruction cases, crown and bridge, partials and dentures, 50% of the fee is due at time treatment begins and balance at time of insertion.

If you have dental insurance, we will accept assignment from your insurance company provided you pay your deductible prior to insertion with the understanding that you will be responsible for any portion not paid by your insurance company within 60 days.

In the event a legal suit or outside collections are necessary to enforce payment of the account, the patient/responsible party agrees to pay for all collection fees and/or attorney's fees and court costs as may be deemed reasonable.

I authorize the release of any information to process the insurance claims.

Signed: _____

I authorize payment of benefits directly to CHILDREN'S DENTISTRY OF CAMP CREEK

Signed: _____

I understand that I am financially responsible for the charges not covered by my insurance company.

Signed: _____

I CERTIFY THAT THE MEDICAL HISTORY IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE READ AND AGREE TO THE CREDIT POLICY AS LISTED ABOVE.

SIGNATURE _____ DATE _____