

Consent/Authorization/Acknowledgement

Clinical

- 1: I authorize Hagen Dental referred to as "practice" hereafter, to take necessary radiographs, study models, photos and other diagnostic aids as needed to make a thorough diagnosis. I authorize photos and radiographs to be emailed to referring providers and insurance companies.
- 2: I authorize this practice to perform all recommended treatment and agreed upon treatment. I also authorize the use of anesthetics sedatives and other medication (as needed) and am fully aware that using anesthetic agents involves certain risks.

Financial

- 3: I am responsible for payment for all services rendered on my behalf and my dependents. I have been informed that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR is automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will assume all additional collection costs and legal fees.
- 4: A \$75 Broken Appointment Fee will be charged to my account for all broken and/or last minute cancellations. I am aware that to hold down operating costs, 24 hours notice of cancellation is required.

Insurance

- 5: I authorize this practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records and radiographs about my medical history, services rendered and treatment necessary.
- 6: I authorize this practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to this practice the insurance benefits providing assignment is accepted. I understand that I am responsible for payment regardless of the coverage provided.
- 7: I understand I am responsible for the deductible, co-payment and excess over maximum the day of service.

Health Insurance Portability and Accountability Act 1996:

HIPAA: Acknowledgement of Receipt of Notice of Privacy Practices:

(You may refuse to sign this Acknowledgement)

- 8: I have received a copy of this practice's Notice of Privacy Practices.

HIPAA: Consent for Use and Disclosure of Health Information:

(Notice of Privacy Practices: You have the right to read this practice's Notice of Privacy Practices before you decide to sign this Consent. Our Notice of Privacy Practices 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. Please read this Notice prior to signing this Consent. This practice reserves the right to change the privacy practices as described in our Notice of Privacy Practices. If changes are made, a revised Notice of Privacy Practices containing the modifications will be issued. These changes may apply to any of your protected health information that we maintain on file. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting: Contact Person: _____ Telephone: _____ Address: _____)

Your have the right to revoke this Consent for use and Disclosure of Health Information at any time by giving us written notice of your revocation submitted to the Contact Person listed above. This revoke will not affect previous consent. We reserve the right to provide further treatment in your behalf or that of your dependents if this Consent is revoked.

- 9: I have had opportunity to review and obtain a copy of this practice's Notice of Privacy Practices. I hereby authorize, as indicated by my signature below, to use and disclose my protected health information to carry out treatment payment activities and health care operations.

Signatures below indicate that I have read this entire document and fully understand the contents of this Consent/Authorization/Acknowledgement. I have been provided with the opportunity to ask questions and obtain further clarification.

SIGNATURE Circle One: Adult Patient/ Parent/ Guardian/ Personal Representative / Date

Please list the names of individuals you permit to disclose your protected health information:

- 1.
- 2.
- 3.
- 4.
- 5.

Please advise us your preferred means of communication:

- You may contact me at work
- You may NOT contact me at work
- You may NOT contact me at home or leave messages
- You may email me over an unsecured network
- List your other preference _____