ADAMS DENTAL GROUP

HIPAA CONSENT

Please update patient information:

Name (Print Name): _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email:(Print Clearly)_____

ARE WE ALLOWED TO LEAVE A DETAILED TEXT, EMAIL, OR VOICEMAIL MESSAGE?

YES NO

IT IS THE PATIENT'S RESPONSIBILITY TO KEEP PHONE NUMBERS, EMAIL AND ADDRESSES UP TO DATE. WE WILL CONFIRM VIA EMAIL, TEXT, AND PHONE CALLS

TO WHOM MAY WE SHARE YOUR PROTECTED HEALTH INFORMATION WITH?

NAME: _____RELATIONSHIP: _____PHONE: _____

NAME: _____RELATIONSHIP: _____PHONE: _____

NAME: _____RELATIONSHIP: _____PHONE: _____

PHARMACY INFORMATION:

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

Do you have any Drug Allergies: _____

SEE NEXT PAGE (OVER)→

NOTICE OF PRIVACY PRACTICES AND OFFICE POLICY

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE PRIVACY POLICY NOTICE (HIPAA) AND OFFICE POLICIES AND PROCEDURES. WE WILL ONLY USE YOUR PROTECTED HEALTH INFORMATION (PHI) FOR THE PURPOSE OF TREATMENTS, PAYMENTS, HEALTHCARE OPERATIONS, AND COORDINATION OF CARE.

FAILED APPOINTMENT POLICY

I FURTHER UNDERSTAND THAT IF I FAIL TO SHOW UP FOR AN APPOINTMENT OR GIVE LESS THAN 24 HOURS NOTICE, **I WILL INCUR A $50.00 FEE FOR EACH APPOINTMENT**. Multiple Failed Appointments could result in termination from the practice. Billing Fees could be applied to any balance aging past 30 days.

PATIENT SIGN: (Parent OR Guardian if applicable): X

X-RAY RELEASE

I authorize the transfer of radiographs and dental records for the referred treatment in the event of transfer to another general dentist or dental specialist.

INFORMED CONSENT AGREEMENT

I give consent to receive dental treatment deemed necessary by the providers at Adams Dental Group. These procedures include, but are not limited to examinations, oral prophylaxes, fluoride treatments, sealants, fillings, crowns, bridges, implants, dentures, periodontal treatment, extractions and the use of local anesthetic and nitrous oxide. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or in rare cases, prolonged or permanent nerve damage. This consent shall be considered in effect until rescinded or revoked in writing.

SIGN: X

PATIENT SIGNATURE (Parent OR Guardian if applicable) DATE