

130 N. Fond du Lac Ave.

Campbellsport, WI 53010

PATIENT CONSENT FORM

HIPAA

I understand that, under the Health Insurance Portability & Accountablility Act of 1996 (HIPAA). I have certain rights to privacy regarding my 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 health/dental care operations such as quality assessments and doctor certifications.

I have been informed by you of your Notice of Privacy Act Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Act Practices prior to signing this consent. I understand that this office has the right to change these practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Act 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/dental care options. I also understand that you are not required to agree to my requested restrictions, but if you do agree you are bound by 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.

I understand that if I choose to deny this consent, I am responsible for any charges not paid by insurance due to this action.

No mobile information will be shared with third parties/affiliates for marketing/promotional purposes. All the above categories exclude text messaging originator opt-in data and consent; this information will not be shared with any third parties.

Campbellsport Family Dentistry] is committed to safeguarding the privacy of our users. We want to assure you that we do not share your personal information with third parties. This privacy policy outlines how we collect, use, and protect the information you provide to us.

Information Collection:

We collect only the information necessary to provide and improve our services. This may include name, email address, etc. We do not sell, rent, or share this information with any third parties.

How We Use Your Information:

No personal information, mobile number, or messaging consent information will be shared with third parties or affiliates for marketing or promotional purposes.

Your Choices:

You have the right to access, correct, or delete your information. If you have any concerns or questions about your data, please contact us at [contact information or link].

Policy Changes:

We may update our privacy policy from time to time. Any changes will be communicated to you, and your continued use of our services implies your acceptance of the updated policy. By using our services, you agree to the terms outlined in this privacy policy.

Last updated: 10/8/2025

*By clicking 'Submit', you agree to Campbellsport Family Dentistry's Terms of Use and Privacy Policy. You consent to receive phone calls and SMS messages from Campbellsport Family Dentistry to provide updates and information in regards to your business with Campbellsport Family Dentistry. Message frequency may vary. Message & data rates may apply. Reply STOP to opt-out of further messaging. Reply HELP for more information. See our* [*Privacy Policy*](/new-patient-forms#4e65b608-6ff4-40a0-a831-0d99122824c9)*.*

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship(if POA/Spouse/Parent):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I wish to allow access to the following individual(s)/Emergency Contact(s):**

(This is so that we may provide information to spouses, parents of adult children, caregivers, ect.)

\*Please indicate:
 \_\_\_Account/Payment Access \_\_\_Dental Records/Appointment Access \_\_\_Treatment Update

Name of Person(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Their Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_