CONSENT FOR DENTAL HYGIENE TREATMENT

Patient Name:_____ Sex:__M __F Date: _____
Facility Name: _____Phone #: _____
Address: _____
City/State: _____ Zip Code: _____
SSN: _____ - _____- _____ DOB: ____/____/_____ Room #: _____ Facility Lic #: _____
Medicare #: _____ Medi-Cal #: _____

Full payment is required from the responsible party at the time of service unless arrangements are made in advance. **A super-bill can be provided for reimbursement from your dental insurance provider.**

Prophy & Deep Cleaning Fees Include: Infection Control, Fluoride, Head & Neck/ Oral Cancer Exam, Oral Hygiene Instructions, Dental Hygiene Supplies, Travel, Administrative, and DDS/MD/RN consultation.

I request to have dental cleaning every: __ 3 Months __ 4 Months __ 6 Months

Privacy Practices

THIS NOTICE DESCTIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to maintain the confidentiality of your health information. We realize that these laws are complicated, but we **must provide you with the following important information that describes how we may use and disclose your protected health information to carry** out treatment, payment of health care operation, and for other purposes that we are permitted or required by law.

We will use and disclose your protected health information to provide, coordinate, or manage your dental care and related services. For example, your health /dental information may be provided to a dentist to whom you have been referred, to ensure that the dentist has the information necessary to diagnose or treat you.

In addition, we may disclose your protected health information periodically to another dentist, physician, or health care provider who becomes involved in your care. We may use and disclose dental information about you to obtain payment for services rendered. Such disclosures may be made to you, and insurance company, responsible party, or third party. We may also tell your health plan about a treatment you are going to receive to obtain approval or to determine whether your plan will cover treatment.

_ I give consent for dental hygiene and preventive treatment for the patient.
_ I reviewed the Privacy Practices above.
_ Permission is granted for Review of Medical Records.
_ Permission is granted to take pictures and/or video of patient for chart ID, or educational purposes.
Email address may be used to receive communications and/or other pertinent information.

All fees are ultimately the responsibility of the "Financial Responsible Party."

Name of Responsible Party: _____
Relationship to Patient: _____
Mailing /Billing Address: _____
City/State/Zip Code: _____
Phone #: _____ Email: _____

Signature of Responsible Party/ POA for Healthcare_____ Date:_____
Signature of the Financial Responsible Party _____ Date: _____