MIRAGE DENTAL CARE

HIPPA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You can ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

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Print Name: ____

Signature: ____ Date: ____________________

PATIENT FINANCIAL INFORMED CONSENT

I acknowledge and agree: The doctor has explained to me all risks, benefits and alternative options regarding my treatment. I have the option of selecting either covered benefits, or available enhanced, upgraded or non-covered dental services. The estimated out-of-pocket patient costs of each option have been fully explained to me. I have requested the services above and agree that I am financially responsible for the patient costs for all dental services provided. This is an estimate only. As such an estimate or preauthorization may not be honored by my dental benefit company upon claim submission. I am financially responsible for all dental services furnished. I am also financially responsible for actual fees and lab charges for treatment started and not completed by me, if applicable.

Signature of Patient: ________________________________ Date: ____________________