

## PATIENT CONSENT FORM

LESLIE P. DILLARD, DDS

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

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

Relationship to Patient: \_\_\_\_\_

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

You are financially responsible for all business conducted through our office. We will gladly file your insurance for you once we are provided all necessary information; however, you are responsible for your balance in the event that we are unable to collect from your insurance provider. After 90 days, your balance will be subject to a 1.5% finance charge. In the event that your balance is turned over for collection, you are responsible for collection cost, attorney fees, and court costs. In the event that you are unable to keep a scheduled appointment with our office, we require 24 hours notice. Without 24 hours notice your account will be charged \$35.00 in order to recover some of our incurred expense.

I have read, understood, and agree to these terms listed above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date