DUBOIS DENTISTRY

General Consent and Consent for Treatment

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform my doctors at the next appointment without fail.

I hereby consent to and authorize dental treatment rendered by Dr. Kenneth Richard DuBois, II, Dr. Anne DuBois, and any temporary providers who this office sees fit to render dental care on behalf of the above-listed providers. I hereby consent to the release of dental or incidental information that may be necessary for dental care, records release &/or transfers, insurance claims and any other reasonable and customary process by this dental office. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This dental office cannot render services on the assumption that the charges will be paid by an insurance company. DuBois Dentistry will help prepare the patients insurance forms &/or assist in making collections from insurance companies and will credit any such collections to the patient's account. I authorize direct payment of insurance benefits to be paid to this office on my behalf. I understand that I will be charged 1.5% monthly interest (18% annual interest) on any balance owed over 90 days old. I further understand that if it is necessary to turn this account over to a collection agency, I will be held responsible for the balance due along with any applicable interest, collections, and attorney's fees.

Print Name: _____

Signature of patient, parent, or guardian **Date** **Relationship to Patient**

Consent for Use and Disclosure of Health Information (HIPAA)

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the entity listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Print Name: _____

Signature of patient, parent, or guardian **Date** **Relationship to Patient**