Jackson Dental Clinic
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
Health Insurance Portability Accountability Act (HIPPA) 1996
http://www.hhs.gov/ocr/hitma/finalreg.html

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name:_____

(PRINT NAME HERE)

SECTION B: To the Patient/Guardian — Please Read the Following Statements Carefully

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, and of other important matters about your protected health information. A copy of our Notice is posted in our waiting room. 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 You may obtain a copy Of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: **Jackson Dental Clinic, 345 North Mart Plaza, Jackson, MS 39206 601-981-1000**

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 Contact Person 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 we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE:_____ DATE: _____

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 health care operations.

SIGNATURE: _____ DATE: _____

Consent for Services:

The practice depends upon reimbursement from the patients for the costs incurred in their care.
All emergency dental services or any dental services performed must be paid for in full at the time services are performed. **We do not offer payment plans. Keep in mind all patients with insurance are given an estimate of charges, this is not a guarantee of payment and if insurance does not cover the estimated charges for insurance the patient will be responsible for billing because we are an out of network provider.**
WE DO CHARGE $25 MISSED APPOITNMENT FEES IF AN APPOINTMENT IS NOT CANCELLED 24/hrs in advanced of a scheduled appointment. Please contact the office prior to appointment dates to cancel to disregard last minute cancellations.
In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I further agree that if partial payment is made and a change of mind follows, there will be no reimbursement of payment due to lab fees.
I have read the above conditions of treatment and payment and agree to their consent.

_____ **Date:**_____ **Relationship to Patient:** _____
Signature of patient, parent or guardian & guarantor of **payment/responsible party**