PERIODONTIC SPECIALISTS

CONSENT FOR CARE AND TREATMENT

I, the undersigned do hereby agree and give my consent for Periodontic Specialists to furnish medical/dental evaluation, care and/or treatment to me or someone I am authorized to make medical decisions for. This evaluation, care, or treatment is considered medically necessary and proper in the diagnosing or treatment of his/her/my physical condition. I understand that even though I give my consent for evaluation, care, or treatment, I may refuse any of these services at any time.

FINANCIAL POLICY STATEMENT

Periodontic Specialists will bill your health insurance company as a courtesy to you. We require that payment of your estimated share (co-pay or deductible) be made on the date of service. If your insurance company does not remit payment for any reason the balance due will be your responsibility. In the event your insurance company requests a refund of payment or denies coverage for your service, you will be responsible for the balance due. If payment is made to you for services provided by Periodontic Specialists, you are obligated to promptly pay for those services. Any questions regarding your insurance coverage need to be directed to your insurance carrier. You will be responsible for all fees incurred for collections of monies owed including collection agency fees/attorney fees and/or court costs.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby authorize release to my insurance company of all information necessary for the payment of benefits. I hereby assign payment of benefits by my insurance company or Medicare to Periodontic Specialists.

Patient's (or representative's) Signature:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY (NP)

A Notice of Privacy (NP) has been made available to me by Periodontic Specialists. The NP describes how my health information may be used or disclosed and my rights under the Health Insurance Portability and Accountability Act (HIPAA).

Please initial: **Notice of Privacy accepted** _____ **Notice of Privacy denied** _____

I am giving my consent for release of **minimal** health information or financial information to the following individuals:

Name	**Relationship**	**Date of birth**
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that I have the right to change (in writing) the above named individuals at any time.

☐ I further authorize Periodontic Specialists to communicate with me electronically through e-mail or text at the following e-mail/text address/number:_____. **I understand that this e-mail or text communication is not secured by encryption therefore is not considered a secured or private communication. Periodontic Specialists will not be held responsible for further disclosure of your information sent via unencrypted e-mail or text.**

Patient's signature: _____

For authorization of e-mail/text communications.