PATIENT CONSENT FORM

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 also reserve 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 how my protected health information is used and disclosed to carry out treatment, payment, and health care operation, 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.

As a courtesy, we do accept assignment of benefit payments from most insurance companies. However, all other estimated balances are due as agreed upon. We are always happy to help you with submitting your claims, but we can make no guarantee about your insurance assistance or benefits. Treatment involving lab related work must be completed within 3 weeks or a remake charge may be added

We will gladly provide an ***estimate*** based on the limited information provided by your insurance company. If you have received treatment by another dentist or specialist, your yearly benefits will decrease and may affect estimated payments. ***Please remember that your dental insurance is your responsibility.***

Unpaid balances over 30 days will be due immediately or considered a delinquent account. In the event that your account remain delinquent for 90 days or more, the account will be turned over to a collection agency and will accrue a 20% administrative collection fee.

Cancellations with less than 24 hours notice may require a deposit for future appointments.

Signed this _____ day of _____, 20___.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Old Trolley Dental Associates
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Summerville, S.C. 29485