SANDHILLS PEDIATRIC & FAMILY DENTISTRY
Consent for Use and Disclosure of Health Information

Purpose: In cases where Sandhills Pediatric & Family Dentistry has directed not to rely on Acknowledgments as a basis to use or disclose health information, this form is used to obtain a patient's consent to your use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

STREET CITY STATE ZIP

Telephone: ____ Email: ____

SECTION B: TO THE PATIENT – 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 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 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:

Our Management Staff
(T) 919.499.9950 (F) 919.499.9940 Email: Sandhillsdental@windstream.net
55 Amarillo Lane
Sanford, NC 27332

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 the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

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: _____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

SECTION C: PERMISSION TO DISCLOSE INFORMATION

Do you give permission to disclose your health information, treatment, appointment, or payment to a family member (s), friend(s), or other person(s)? If so, please list them below.

Name: ____ Relationship to Patient: _____________________________

Disclose information pertaining to: ______health information; ______treatment; ______ appointment; ______payment

If the patient is a minor, do you grant the person above permission to bring your child to an appointment and make treatment decisions on your behalf? _____ yes _____ no

Name: ____ Relationship to Patient: _____________________________

Disclose information pertaining to: ______health information; ______treatment; ______ appointment; ______payment

If the patient is a minor, do you grant the person above permission to bring your child to an appointment and make treatment decisions on your behalf? _____ yes _____ no

Name: ____ Relationship to Patient: _____________________________

Disclose information pertaining to: ______health information; ______treatment; ______ appointment; ______payment

If the patient is a minor, do you grant the person above permission to bring your child to an appointment and make treatment decisions on your behalf? _____ yes _____ no

Name: ____ Relationship to Patient: _____________________________

Disclose information pertaining to: ______health information; ______treatment; ______ appointment; ______payment

If the patient is a minor, do you grant the person above permission to bring your child to an appointment and make treatment decisions on your behalf? _____ yes _____ no

Name: ____ Relationship to Patient: _____________________________

Disclose information pertaining to: ______health information; ______treatment; ______ appointment; ______payment

If the patient is a minor, do you grant the person above permission to bring your child to an appointment and make treatment decisions on your behalf? _____ yes _____ no

SECTION D: PHOTOGRAPHIC RELEASE AND CONSENT

I, ____, hereby authorize and consent to **Sandhills Pediatric and Family Dentistry** and its representatives the irrevocable and unrestricted right to reproduce, publish, print, use and distribute digital photographs and/or diagnostic x-rays of me, either in an official medical publication or in lectures for educational purposes. I further grant permission for my photos to be used on the Sandhills Pediatric and Family Denistry website, social media sites, or any other lawful purpose for advertising. I release Sandhills Pediatric and Family Dentistry and its employees and legal representatives from any and all claims, actions and liability relating to its use of said photographs.

The following exclusions may apply:

____

Signature: ____ Date: ______________________

MINORS ONLY:
If signature above is by a person under the age of 21, parent or guardian should sign below:

I _________________________________ the parent or guardian, hereby consent to the foregoing.

Signature: ____ Date: ______________________

SANDHILLS PEDIATRIC & FAMILY DENTISTRY FINANCIAL RESPONSIBILITY

Payment is due at the time of service. We accept cash, debit cards, VIS, MASTERCARD, DISCOVER, CareCredit, and CitiHealth as a means of payment. As a courtesy, if you have dental insurance, we will file it for you. We encourage you to become familiar with the limitation of your dental plan (i.e., coverage, deductibles, frequencies, of procedures and copayments), as we will collect your cost share the day of service. On average, insurance claims are paid within 30-45 days. If your insurance claim is not paid within that time, you will receive a bill for payment. Upon receipt of payment from your insurance, we will kindly remit the credit balance to you. Your account will be assessed additional fees and collection charges of 1.5% if not paid within 30 days.

To avoid broken appointment and cancellation fees, we request a 24-hour courtesy call to cancel your reservation with us. A 48-hour courtesy call is requested for Saturday and appointments requiring an extended amount of time (i.e., root canal therapy; IV Sedation; oral sedation; oral surgery). You will be advised of the proper cancellation policy when you schedule your appointment.

SANDHILLS PEDIATRIC & FAMILY DENTISTRY AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and accurate. It is my responsibility to inform Sandhills Pediatric and Family Dentistry, Brooks and Dunston DDS, PLLC of any changes in my personal information (Ie., telephone number, address, insurance carrier, and/or health.)
I understand that I am financially responsible for all charges, whether paid by insurance or not, at the time services are rendered. I authourize the use of my signature and authorize this office to submit claims, and assign benefits on my behalf to ____Insurance Company. Sandhills Pediatric and Family Dentistry, Brooks and Dunston DDS, PLLC may use my health care information and may disclose information to my Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Signature of Patient: ____ Date: ______________

Signature of Parent or Legal Guardian: ____ Date:____________