LIBRARY PLAZA DENTAL CENTER
FAMILY, COSMETIC, & IMPLANT DENTISTRY

Name _____

TREATMENT & HIPAA CONSENT **Date** ____/____/____

TREATMENT CONSENT

Cancellation policy: Once an appointment is made, our time is reserved for your visit. 48 hours notice is appreciated for appointment cancellation. Appointment cancellation with less than 24 hours notice will be considered a missed appointment and subject to a $25 cancellation fee. Repeated missed and/or canceled appointments impact our ability to provide patient care and may result in dismissal from the practice.

I certify that I have read and understand the 'Patient Information' and 'Dental & Medical History' forms and that the information I provided is accurate. I understand that providing incorrect and/or inaccurate information may be hazardous to my health. I will inform the office of any health changes at my next appointment.
I agree to the use of anesthetics, sedatives and other medication as necessary to receive treatment. I understand that I can ask for a complete recital of any possible complications from anesthetics or dental procedures.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependents(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice.

I authorize Library Plaza Dental to take photographs of my face, jaws and teeth. I understand that these photographs will be used as a record of my care and for professional communications, and that these photos may be used for educational purposes, advertising, or professional publication without revealing my identity.

I understand that I am financially responsible for any outstanding balance for services provided to myself or my dependents that are not fully covered by insurance, and that I will be billed for any remaining balance.

Patient Signature / Date _____ ____/____/_____ Relationship to patient: _____

HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communicating among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing competence.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any changes to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Patient Signature / Date _____ ____/____/_____ Relationship to patient: _____