FAMILY
Dental Care

NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the "Notice of Privacy Practice" which provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice in our office or website. If you have any questions about our "Notice of Privacy Practices", please contact us at (619) 422-0300.

By signing this form, I acknowledge receipt of the "Notice of Privacy Practices of Family Dental Care.

GENERAL CONSENT FOR MEDICAL TREATMENT

CONSENT FOR TREATMENT: The undersigned patient, responsible relative and/or patient's legal representative herby voluntarily consent and authorize such care and treatments, including but not limited to examination, diagnostic tests, procedures, and medications by employees and authorized agents of Family Dental Care. I, the undersigned, acknowledge that no guarantees have been made regarding the effect of such treatments on any medical condition.

RIGHT TO REFUSE TREATMENT: The undersigned responsible party further understands that he/she has the right to make informed decisions regarding all care and treatments, and that he/she may ask the healthcare professional to explain anything that is not understood. This right includes the right to refuse any treatments by advising their doctor.

RELEASE OF INFORMATION: I hereby authorize Family Dental Care employees to release such medical information from my medical records as is necessary to complete forms for continued care, payment by insurance carriers, health care plans, and third party payers including employers, health services plans or worker's compensation carriers. I, the undersigned, acknowledge having received a Notice of Privacy Practices which outlines which health information may be used or disclosed. I, the undersigned, consent to such disclosures as delineated in the Notice and understand that this may include information related to HIV/AIDS, behavioral health services and treatment for alcohol and/or drug abuse.

ASSIGNMENT OF HEALTH BENEFITS: I, the undersigned, hereby authorize and instruct the insurance carrier to make payments directly to Family Dental Care for my dental benefits. I understand that insurance co-payments, co-insurance, and non-covered services are my or my representative's financial responsibility.

FINANCIAL AGREEMENT: I, the undersigned, agree to pay, whether signing as a patient or representative of the patient, the charges incurred at Family Dental Care in keeping with the established fee schedule. I understand that if I am a member of a Health Maintenance Organization (HMO) and have not secured authorization for payment of services, I will be held financially responsible for all non-covered services. I also understand that I am responsible for any balance owed and that a cash deposit will be required for patients not otherwise approved for the sliding fee of public benefits.

ADVANCE DIRECTIVES: Adults 18 and older have the right (a) to give direction about their future medical care or (b) to designate a patient representative to make medical decisions for them if they lose individual decision-making capacity. I, the undersigned, understand that information about advance directives is available to me upon request.

Patient Name:_____Date:_____

Date of Birth:_____

Patient / Legal Representative Signature:_____

Legal Representative Name:_____

Legal Representative Relationship to Patient: _____