

**HIPAA**

I consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations by PSFD. I have the right to read the Notice of Privacy Practices before deciding to sign this Consent. This Notice provides a description of the uses and disclosures taken to my protected health information, and of other important matters about my protected health information.

I also have the right to revoke this Consent at any time by giving PSFD written notice of revocation submitted to the office manager or treatment provider. (Note: Revocation of this Consent will not affect any action taken in reliance on this Consent before receiving the revocation, and that PSFD may decline to give treatment or to continue treatment once this Consent is revoked.)

**CONSENT FOR TREATMENT**

I hereby authorize PSFD and/or designated staff to take radiographs, study models, photographs, and any other diagnostic aids deemed appropriate by a doctor to make a thorough diagnosis.

Upon such diagnosis, I authorize Dr. David P. Cartago and other PSFD Provider(s) to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required for proper care.

I agree to the use of anesthetics, sedatives, or other medication as necessary. I fully understand that using anesthetics agent embodies certain risks. I understand that I can ask for complete recital of any possible complications.

**ASSIGNMENT AND RELEASE**

I certify that I, and for my dependents, have insurance coverage indicated on the Patient Registration, and assign directly to Dr. David P. Cartago, Perfect Smiles Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. PSFD may also use my health care information and may disclose such information to the Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date of my last treatment.

**DENTAL MATERIALS FACT SHEET**

I acknowledge that I have received the Dental Materials Fact Sheet developed by the Dental Board of California. I understand that this sheet has been provided to me in an effort to ensure I am fully informed of the variety of materials available for dental restorations. I understand that I should review this information to make a fully informed decision regarding dental restorative treatment. I also understand that if I have questions or concerns regarding this information that it is my right to have a discussion regarding this aspect of my care with the dentists.

**ACKNOWLEDGE UNDERSTANDING AND ACCEPTANCE OF THE FOLLOWING OFFICE POLICIES:**

(24-Hour Cancellation Policy) :: Each patient is required to provide advanced notice to allow PSFD to arrange office schedules. Failure to notify any cancellation of appointments 24 hours in advance will result in a \$25/hour fee. Three such incidents shall be considered as automatic noncompliance and withdrawal of dental treatment.

(Payments):: Co-payments and/or Payments are due when Services are rendered. An estimate of your financial responsibilities shall be provided prior to or during your visit. If you did not receive an estimate, a copy shall be made immediately upon request.

(Insurance Claims) :: We are NOT contracted with your insurance company(ies) and therefore have no authority over eligibility, benefits, fee schedules, or other membership entitlements. Thus as a courtesy, PSFD will process insurance claims on your behalf, but you are still responsible for the payments of services rendered. Any claims outstanding after 60 days will be billed directly to you. Any unpaid balances after 60 days will be submitted to Collections.

(Information Update) :: Each patient is responsible for updating any changes to health, medication, insurance coverage, and/or personal

Patient/Guardian Signature \_\_\_\_\_

Today's Date \_\_\_\_\_