Myers Pediatric Dentistry and Orthodontics

Your Privacy Is Important to Us

I have been made aware of the Notice of Privacy Practices of Myers Pediatric Dentistry & Orthodontics. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

□ You may contact me at my home telephone number and leave a message _____

□ You may contact me on my mobile telephone number and leave a message_____

□ You may contact me on my work telephone number and leave a message_____

□ You may send me an email at: _____

□ Other _____

Please list authorized persons with whom we may discuss you or your child's Protected Health Information (PHI). The persons listed should include and are not limited to custodial parents, biological parents, step-parents, legal guardians, and extended family members such as grandparents and aunts and uncles:

1. _____Date Added / Removed:_____

2. _____Date Added / Removed: _____

3. _____Date Added / Removed: _____

4._____Date Added / Removed: _____

5._____Date Added / Removed: _____

* * *

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communication barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining the acknowledgement

□ Other (Please Specify) _____

Staff Person Initials _____

PATIENT CONSENT

Clinical

1. I authorize Myers Pediatric Dentistry & Orthodontics to perform all recommended treatment presented to me for myself and/or for my child.

2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.

3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

4. Since missed appointments significantly increase costs for care and decrease our appointment availability, the following charges will be assessed for missed appointments and late cancellations. In the event I miss a scheduled appointment or cancel an appointment less than 24 hours prior to the appointed time, I understand I am responsible for the following charges:

   Smile Check Appointments: $25.00 - Operative Appointments: $50.00

   We appreciate your support and understanding as we adopt policies to keep our services accessible and affordable. We realize no one intentionally fails their appointments, but the loss of efficiency negatively affects everyone in the practice.

Insurance

5. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

6. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: _____ DOB: _____

Patient Signature or Parent/Guardian Signature: _____Date: _____

Relationship to Patient: _____