

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patients' rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form I understand that:

- Protected health information may be used or disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

At The Colony Dentist, we schedule our appointments to provide each patient with our undivided attention. In order to accomplish this, we require a 24 hour confirmation on all appointments. **Please be advised you will be charged for cancellations and/or rescheduled appointments with less than 24 hours notice at the rate of \$50.00 for examinations/hygiene appointments and \$75.00 for dental procedure appointments.** Also note the payment for services that are provided by patients for The Colony Dentist will be applied to patient balances. Should the patient change their mind for whatever reason during the treatment, the patient will still be responsible for full payment.

This consent was signed by: _____

(PRINTED NAME)

Signature: _____ Date: _____