CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND SIGN AT THE BOTTOM OF PAGE.

PUROSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health information, and of our other important matters about your protected health information. A copy of our Notice accompanies this Consent upon request. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: We will gladly furnish you with a set of our Privacy Notice upon request at any time. The Privacy Notice is also displayed on our lobby wall at all times in plain view of our patients. If at any time you have questions or concerns regarding this LAW please feel free to ask us.

Authorization

I have reviewed all the information on all the questionnaires and it is accurate to the best of my knowledge. I understand the information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical or dental history, I will inform the dentist.

I authorize my insurance company to pay Dr. C. Christian Franck III. DDS., all insurance benefits that apply to treatment received and the use of my signature on all dental claims.

I understand that I am Financially Responsible for all charges that apply to my treatment. All payments are due at time of visit. No payments will result in collection recovery, including all and any additional fees that may occur.

Date _____ Name _____