FEES & PAYMENTS

As a courtesy to our patients, we will file to your insurance company on your behalf. However, our professional services are rendered to you, or your child, and not the insurance company. Therefore, you are directly responsible for the cost of treatment. By signing below, you are promising to pay for the professional services provided to you by Heartland Oral Surgery and Dental Implants. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X_____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

I authorize my surgeon and other healthcare professionals of Heartland Oral Surgery and Dental Implants to perform diagnostic procedures and treatment as may be necessary for proper care. To the best of my knowledge all the information provided regarding medical history and status is complete, true and correct and may be relied upon for all purposes by Heartland Oral Surgery and Dental Implants in treating or assisting in the treatment of the patient. Changes in medical history will be made available upon subsequent appointments.

X_____ X _____

Signature of patient: *(Parent or Guardian if Minor)* **Date**

PRIVACY NOTICE RELEASE

My personal health information is private and confidential. I understand that my doctor and his staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my doctor and his staff may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

I can ask my doctor to limit how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that my doctor may deny my request. If my doctor does agree to my request, I understand that my doctor and his staff would follow the agreed limits.

I may cancel this consent at any time by doing the following:

1. Signing and dating a written request to your doctor specifying what information you wish to restrict and to whom the restriction applies. You will receive a written response to your request.
2. Writing, signing, and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment, and healthcare operations.

If I cancel this consent, my doctor and his staff do not have to provide any further health care services to me.

My doctor has a detailed document called the “Notice of Privacy Practices”. It contains more information about the policies and practices protecting my privacy. I understand that I have the right to read the “Notice” before signing this agreement. My doctor may update this “Notice”.

If I ask, my doctor or his/her staff will provide me with the most current “Notice” and the current “Notice’ will always be available at my doctor’s office. I give permission for the following individuals to have access to my private health information:

Name	Phone #	Name	Phone #

We may send private health information such as appointment conformation, procedure instructions and test results to your email, your cell phone via text, your answering machine and / or your voicemail. If you choose to opt out of one of these methods, please mark below:

o Email **o** Text **o** Answering Machine **o** Voice Mail

My signature below indicates that I have been given the chance to review a current copy of my Doctor’s “Notice of Privacy Practices”. My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment, payment and healthcare options.

X_____ X _____

Patient *(or legally authorized individual)* **Signature** **Date**

X _____

Relationship to Patient