Consent for Treatment
Assignment of Benefits/Financial Responsibility
Release of Information
Notice of Privacy Practice Acknowledgement

I consent for medical treatment by ToothBuds at Lagoon Park, LLC.

I authorize ToothBuds at Lagoon Park, LLC to file for insurance benefits on my behalf for covered services rendered. I authorize the release for medical information for insurance claims and the release of past medical payment history, if needed. I understand that I am responsible for co-pays; deductibles and co-insurances at the time services are rendered. I also understand I am responsible for any non-covered services. Patients also are responsible for any collection and legal fees in the event of default.

I authorize the release of any medical information necessary to process my insurance claim. I also certify that the information I have reported with regard to my insurance coverage is correct.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and health information used by us in any form are kept confidential. This Act, gives you, the patients, significant new rights to understand and control how your health information is used. HIPPA provides penalties for misuse of personal health information. I you wish to review these procedures further please ask for more information and we will provide this for you. If you would like a copy of the (HIPAA) Privacy Practice we will be glad to provide you with a copy.

You have the following rights with respect to your Health information:
1. The right to, access, inspect, and copy your health information.
2. The right to request an amendment to your health information.
3. The right to receive and accounting of certain disclosures of your health information.
4. The right to receive confidential communications.
5. The right to request restrictions on disclosures concerning your health information. _____ (Initial)

******I herby consent that medical information and treatment can be discussed with the following person or persons. If you want this information only discussed with you leave the following blank. An example would be Spouse, parents etc.

_____ _____

_____ _____

******I herby consent that appointments reminders can be left on answering machine or with a family member. _____ (Initial)

(HM #)_____ (WK #)_____ (Cell #) _____

_____ _____
Date Signature of Parent/Guardian (must be 18)

Please list patient(s) this applies to: _____