Scurlock Dental Care

Consent for Use and Disclosure of Health Information

Section A: Patient Giving Consent

Name:_____

Address:_____

Telephone:_____ Email:_____

Patient:_____ Social Security:_____

Section B: To the Patient- Please Read the Following Statements Carefully

Purpose of Consent: By signing this form you will consent to our use and disclosure of your health information to carry out treatment, payment activity, 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 healthcare operations, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notices at any time by contacting: Dr. Steven M. Scurlock, D.D.S.

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 listed above. 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 continue treating you if you revoke this Consent.

I,_____ have had full opportunity to read and consider the consent form and your Notice of Privacy Practiced. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Authorization: I authorize payment of dental benefits to the named provider for professional services rendered and the release of any dental information neccessary to process this claim.

I grant authority to the dentist to perform procedures and treatments, including administration of medicine, local and general anesthetics, and extractions along with other surgical and dental procedures that may be neccessary.

I agree to pay collection cost and/or reasonable attorney fees if any deliquent balance is placed with an agency or attorney for collection or suit. I also agree to pay a late fee of 1.5% per month if my account goes over 90 days past due, resulting in 18% per annum.

Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees for services rendered.

Authorized Signature_____

If this consent is signed by a personal representative on behalf of the patient, complete the following.

Representative's Name_____ **Relationship to Patient**_____

You are entitled to a copy of this consent after you sign it.