Acknowledgment of Receipt of Notice of Privacy Practices and HIPAA Non-Secure Communication Consent Form

Patient Name:	Date of Birth:

This consent form allows The Canyon Lake Center of Family & Cosmetic Dentistry to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

The Canyon Lake Center of Family & Cosmetic Dentistry has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at The Canyon Lake Center of Family & Cosmetic Dentistry.

____ Initial I hereby authorize Canyon Lake Center of Family & Cosmetic Dentistry to use unsecured email and mobile phone text messaging to transmit to me the following protected health information: 1) Information related to the scheduling of appointments; and, 2) Information related to billing and payment.

____ Initial I hereby authorize that Canyon Lake Center of Family & Cosmetic Dentistry may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

___ Email ___ Home Phone ___ Office Phone ___ Cell Phone

____ Initial I hereby authorize that Canyon Lake Center of Family & Cosmetic Dentistry may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the office while I meet with my dentist and staff.

____ Initial I hereby authorize that Canyon Lake Center of Family & Cosmetic Dentistry may disclose my personal health information to the person who I have listed as my emergency contact.

____ Initial I hereby authorize that Canyon Lake Center of Family & Cosmetic Dentistry **may** disclose my personal health information to the following person(s):

Name	Telephone Number	Relationship to Patient

Furthermore, my (or my child's) personal health information **may NOT** be disclosed to the following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Canyon Lake Center of Family & Cosmetic Dentistry services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Canyon Lake Center of Family & Cosmetic Dentistry may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while Canyon Lake Center of Family & Cosmetic Dentistry is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

By my signature below, I affirm the above information.

Signature of Patient/Guardian:_____ **Date:**_____

Authorized Representative:_____ **Date:**_____

CANYON LAKE FAMILY AND COSMETIC DENTISTRY
1339 Canyon Edge, Canyon Lake, TX 78133
Phone: (830) 899-7128
www.CLDentistry.com

FINANCIAL POLICY

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care you need or desire. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health. In our office, we strive to maximize your insurance benefits and make any remaining balance affordable.

Our fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment.

If you have insurance benefits, we will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your benefits. Your insurance policy is an agreement between you and the insurance company; we ask that all patients be directly responsible for all charges. Your **estimated** co-payment will be due at the time of service. We are happy to submit the claims necessary to help you receive the full benefits of your coverage; however **we cannot guarantee any estimated coverage**. Please know that we will do everything possible to see that you receive the full benefits of your policy.

Payment for services is due at the time services are rendered. If you have an unpaid balance from previously rendered services at our office, you will be expected to pay this before continuing with any future treatment.

We accept the following **payment options** for your convenience:

1. Pre-payment courtesy: A 5% pre-pay courtesy is given when treatment is pre-paid in full at time of scheduling the appointment. (cash, check, or credit card)
2. Pay for services at the time treatment is rendered.
3. Payment plan programs available upon request and approval.

❑ Please check if you would like more information about financing or extended payment options.

I have read and agree to the Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date