Newton Wellesley Dental Partners

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION & DENTAL TREATMENT

SECTION A: PATIENT GIVING CONSENT

Name:____

Address:____

Telephone:_____________________________ E-mail:____

Patient Number:_________________________ Social Security Number:____

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 protected health information to carry out treatment, payment activities, insurance, 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 disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. 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 Notice, at any time by contacting:

Contact Person: Ryne S. Johnson, DMD Telephone: 617.965.1225 Fax: 617.965.1250
E-mail: info@NewtonWellesleyDentalPartners.org Address 447 Centre Street Newton, MA 02458

The undersigned hereby authorizes the doctor/practice to take x-rays, CT scans, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand the responsibility of payment for dental services provided in this office for myself or my dependents is mine; due and payable at the time services are rendered unless written, financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. Where applicable, I also assign all insurance benefits to the Practice.

The undersigned also authorizes contact from the office via post card or email for the purposes of appointment confirmation and office correspondence that relates to treatment plans, x-rays, rescheduling appointments and general practice updates. Your email address will never be sold or disseminated for advertising purposes.

I,____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. 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 health care operations.

Signature:____ Date:_____________________________

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 to continue treating you if you revoke this Consent. I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations. I understand that this revocation will not affect any action you took prior to this date and that you may decline to treat or continue to treat me after I have revoked my Consent.

Signature:____

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

Personal Representative's Name:____

Relationship to Patient:____

Signature:____ Date:_____________________________