CLEAR CREEK DENTISTRY

Consent for Services

Name ______________________________ Date ______________

As a condition of treatment by this office, financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. Patients with dental insurance understand that all dental services are subject to the dental insurance contract established between their employer and their insurance company, and that he or she is personally responsible for payment of all dental services. As a service to you, we will complete and file your insurance claim forms and assist in making collections from insurance companies. Insurance collections will be credited to the patient's account. The patient estimated portion of payment is expected at the time of treatment. A service charge of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied. I understand that any fee estimate for this dental care can only be extended for a period of three months from the date of the patient examination. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

AUTHORIZATION TO RELEASE INFORMATION

Clear Creek Dentistry is hereby authorized to release any medical or incidental information that may be necessary for medical care, or in the processing of my dental insurance.

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of office health care operations. The Notice of Privacy Practices also describes my rights and Clear Creek Dentistry's duties with respect to my protected health information.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby authorize disclosure of my protected health care information to the person indicated below.

- ☐ Any member of my immediate family
- ☐ Spouse only

I acknowledge that I have read the above statements and conditions and agree to the contents.

Signature of patient, parent, or guardian (responsible party):

Signature: ________________________________ Date: ________________