

UNDER PHYSICIANS CARE FOR: _____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING:

ANY OTHER ALLERGIES YOU HAVE:

OTHER MEDICAL CONDITIONS YOU HAVE:

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- ❖ Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- ❖ Obtaining payment from third party payers (e.g. my insurance company);
- ❖ The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Practice Name: Cox Creek Family Dentistry

Address: 721 Cox Creek Parkway

City/State/Zip: Florence, AL 35630

(Patient Name)

FINANCIAL AGREEMENT

Unless other written arrangements are made before treatment, I agree to pay Cox Creek Family Dentistry, P.C. for dental services the day the services are provided. I agree to pay all charges not covered by my insurance or other third parties. I also agree to pay any and all collection fees, attorney fees and court costs in addition to the balance if this account is placed in collection.

Print Name of Responsible Party

Signature of Responsible Party

Date

Cancellation and Broken Appointment Policy

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplishing that goal. The appointment you schedule for your treatment is reserved for you and your treatment only. We understand that illness, emergencies, and bad weather do occur. We ask our patients to give us 48 hours notice whenever possible, if they cannot keep an appointment. This allows us to fill our schedule without double booking patients to compensate for missed appointments.

Policy and Fees:

Cancellation or rescheduling of an appointment without giving a 48 hour notice may or may not be considered a broken appointment: it will be at our discretion.

Failure to give 24 hour notice:

- We allow for (1) broken appointment within a 12 month period
- Any additional broken appointment within a 12 month period will be charged a fee
 - \$40 for each hygiene appointment
 - \$50 for each doctor's appointment

We appreciate your understanding and consideration regarding our appointment policy. If you have any questions or concerns, please never hesitate to ask us at Cox Creek Family Dentistry.

I have read and understand the above mentioned policy.

Patient Signature (Parent or Guardian if minor)

Date