

{NAME OF PRACTICE}

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## 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, 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: Dwayne R. Burbach DDS \_\_\_\_\_

Telephone: 805 466 3328 \_\_\_\_\_ Fax: 805 466 0824 \_\_\_\_\_

E-mail: KansasDB@aol.com \_\_\_\_\_

Address: 7005 Atascadero Ave. Atascadero, CA 93422 \_\_\_\_\_

**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.

## SIGNATURE

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: \_\_\_\_\_

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

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

# Dwayne R. Burbach, D.D.S. INC.

7005 Atascadero Ave.  
Atascadero, Calif. 93422  
805-466-3328

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and understanding of our office policy.

## **Understanding Insurance:**

We will bill your insurance as a courtesy, however, we are not responsible for your insurance company's action or inaction in paying for the service. If your insurance company has not paid within 60 days, the charges are then your responsibility.

\*A current insurance card must be provided at the beginning of each visit. If eligibility cannot be verified at the time of service, payment in full is expected.

\*Not all services are covered by all insurances. Please review your insurance so that you are aware of your coverage plan. Knowing your coverage is your responsibility, you will be expected to make payment in full on non-covered services at the time they are received.

## **Payments:**

\*Co-pays, and all deductible payments are due at the time of service.

\*Patients without insurance are expected to pay in full at the time of service.

\*Please send your teenager in for an appointment with proper payment methods arranged.

\*We accept cash, checks, Visa, MasterCard, Discover and debit cards with credit logos on them.

## **Returned Checks & Collections Procedures:**

\*All returned checks are subject to a \$25.00 non-sufficient funds fee. If payment is not made within 10 days to cover the amount of the returned check plus the NSF fee, we then forward the returned check to the District Attorney's office in San Luis Obispo.

\*We reserve the right to forward any balance past due by 60 days to a third party collection agency for collection purposes.

## **Cancellation and No-Show Policy:**

\*Your appointment time is reserved exclusively for you. Please be considerate of others and give 24 hours notice if you need to cancel or reschedule your appointment. Failure to give 24 hours notice for cancellation or reschedule will result in a \$50.00 charge.

\*If you do not arrive for a scheduled appointment, you will be charged a \$75.00 No-Show fee, which must be paid before you can schedule future appointments. Failing to keep 2 appointments in a year will result in the restriction of appointment options. After the third missed appointment, we will not be able to treat your family in the future.

*If you have any questions about the information above, please don't hesitate to ask us, we are here to help you.*

I do hereby consent to and authorize the performance of all examinations and dental treatment by Dwayne R. Burbach and his staff, which they deem advisable. I also acknowledge and understand the office policies and procedures explained above and have received a copy. I hereby authorize my insurance company to pay Dr. Dwayne R. Burbach directly. The copy of this authorization can be considered an original for insurance purposes.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name