Alternative Dental Care

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Consent For Patient Treatment

Last Name: _____ First Name: _____

Sex: Social Security# _____ Phone: _____

Emergency Contact: _____Phone: _____

Relationship to Patient: _____

Patient's Home Address: _____

Name of Special Care Facility: _____

Facility Address: _____

Facility Contact Person: _____Facility Phone: _____

In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to maintain the confidentiality of your health information.
We realize these laws are complicated, but we must provide you with the following important information that describes how we may use or disclose your protected health information to carry out treatment, payment of health care operation and for other purposes that we are permitted by law. We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. For example: your health/dental information may be provided to a dentist whom you have been referred to ensure that the dentist has the necessary information to diagnose and treat you. In addition, we may disclose your protected health information periodically to another dentist, physician or health care provider who becomes involved in your case. We may disclose information about you in order to obtain payments for services rendered. Such disclosures may be made to you, an insurance company, responsible party or third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. By signing below, you are consenting to dental hygiene services provided by Susan Dragoo, RDHAP, Alternative Care Dental Hygiene Practice or an Associate RDHAP of Susan Dragoo, RDHAP, Dental Hygiene Practice, and agree that you will be responsible for all payments (You also agree that Susan Dragoo, Alternative Care Dental Hygiene Practice may review your medical records, and that a photo may be taken for our files.

Name of Responsible Party: _____

Mailing/Billing Address: _____

Email of Responsible Party: _____

Relationship to Patient: _____

All Fees are ultimately the responsibility of the "Responsible Party" within 30 days of service.

Signature of Responsible Party: _____Date: _____

Signature of Health Care Power to Attorney: _____