Person & Darlington
Family and Cosmetic Dentistry

Patrick R. Person, D.D.S, PLLC

Baker Darlington, D.D.S

Consent for Treatment and Financial Policy

Welcome to our dental office. We would like you to be familiar with our treatment and financial policies. The dental practice depends on reimbursement from the patients for the costs incurred in their care.

All dental services furnished are charged directly to the patient, and the patient is responsible for payment. This also applies to the patient's dependents. Our office will gladly file your insurance claims for you, but services cannot be rendered based on the assumption that our charges will be paid by an insurance company. Any fees over the allowance by your insurance carrier are the responsibility of the patient. Fee estimates for dental care can only be extended for 6 months from the date of the examination.

We understand that you are busy, and your time is valuable to us! We pride ourselves on keeping to our schedule. To help us stay on track throughout our day, we ask that you arrive on time for your scheduled appointment. Please call at least 48 hours in advance when changing appointments. Missed appointments without proper notification, or repeated cancellation, will incur a $35 broken appointment fee.

In the event that your account is placed with a Collection Agency, a collection fee of up to 33.30% may be added to your account and shall become a part of the total amount due. You will be responsible for any and all reasonable collection fees including attorney fees and court costs.

You agree, that in order for us to service your account or to collect any amounts you may owe, we and our collection agencies may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to us.

The dental staff might need to take x-rays, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. If treatment is recommended and accepted by the patient, the patient gives authorization to the doctor to perform all recommended treatment mutually agreed upon. Any treatment given might require the use of anesthetics, sedatives, and other medications as necessary. The patient understands that using these agents embodies certain risks. These risks can be discussed at your request.

We are glad to have you as a part of our dental practice! We look forward to caring for you and your dental needs.

I have read the above conditions of treatment and financial policies and agree to their content.

_____ _____ _____

(Signature of Patient) (Date) (Relationship to Patient)

(Parent or guardian required if under 18 years of age)

_____ _____ _____

(Signature of Patient) (Date) (Relationship to Patient)

(Signature of guarantor of payment/Responsible Party)

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HIPAA 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 dental treatment)

- Duties involved in obtaining payment from third party payers (e.g. insurance companies)
- The day to day operations of the dental practice including:
  - Confirming appointments by phone, postcard, email or text
  - Leaving messages regarding pending appointments by voicemail / answer machine.
  - Leaving messages regarding medications or pre-medications that might be needed for an appointment with members of the patient's household.

I understand that I am financially responsible for the entire bill if insurance claims are rejected. I have also been informed of, 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 FUPAA. 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 so agree, you are then bound to comply with this restriction.

Signed _____
(Date)

_____
(Signature)

(Parent or guardian required if under 18 years of age)

_____ _____
(Print Patient's Name) (Relationship to Patient)