# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**SECTION A: PATIENT GIVING CONSENT**

FullName:

Address:

Patient Phone:

**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: Betzy Ruiz

Telephone: 860-367-0688 Fax: 8603670668

E-mail: betzyruizclinicaldirector@gmail.com

Address: 14 Gallivan Lane Uncasville CT 06382

**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: _____

I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual (s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

This dental information may be used by the persons I authorize to receive this information for medical/dental treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date:_____

Signature of Patient

**Affinity Dental Center**
14 Gallivan Lane
Uncasville, CT 06382

# AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE THE ABOVE NAMED DENTIST (S) TO PROVIDE ANY INSURANCE COMPANY (S), CLAIM ADMINISTRATOR (S), AND CONSULTING HEALTHCARE PROFESSIONALS INFORMATION CONCERNING HEALTHCARE, ADVICE, TREATMENT OR SUPPLIES PROVIDED. THIS INFORMATION WILL BE USED EXCLUSIVELY FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS FOR BENEFITS.

---

«FIRSTNAME» «MIDDLENAME» «LASTNAME»

_____

DATE

# HIPAA PATIENT CONSENT FORM

I understand 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 (i.e. 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 healthcare 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.

---

«FIRSTNAME» «MIDDLENAME» «LASTNAME»

---

Print Name

---

Date

---

Relationship

Affinity Dental Center
14 Gallivan Lane
Uncasville, CT 06382

# AFFINITY DENTAL CENTER

14 Gallivan Lane
Uncasville, CT 06382

## Office Policy

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our office policy.

1. Your insurance is a contract between you, your employer and the insurance company. As a service to our patients, this office will bill all primary and secondary insurance companies without charge.

2. We must emphasize as dental care providers, our relationship is with you, not your insurance companies. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date of service. Any balance not payable by the insurance company will be the responsibility of the patient. If you anticipate any difficulties in paying these balances, you should contact the practice administrator prior to treatment so financial arrangements can be made. All co-payments must be made at the time of each visit for any insurance that we accept.

3. Account balances are considered delinquent after sixty (60) days and are subject to collection charges. Interest may also be assessed.

4. Appointments are commitments that you will be expected to keep. Time is set aside exclusively for you and you should plan to arrive promptly as scheduled. We make every effort to see our patients on time.

5. You may be charged for missed appointments if we are not notified at least 48 hours in advance. Your insurance will not cover this charge and you will be responsible for payment. This charge is not automatic, but will be made at the discretion of the Doctor in accordance with each circumstance. Continual missed appointments may result in loss of appointment privileges.

6. Should you have any questions regarding this office policy, please see the practice administrator or one of our administrator team members for assistance.

Patient's Signature Date:

# EMAIL/TEXT APPOINTMENT REMINDER CONSENT

Patient's Name (please print):_____

**Affinity Dental LLC,** now has the ability to email and/or text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign.

**Consent to Email and/or Text Message for Appointment Reminders and Other Healthcare Communications:**

**Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.**

I consent to receiving appointment reminders and other healthcare communications/information at that email and/or text from Affinity Dental LLC,

_____ (***Patient initials***) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number.

The **cell phone number** that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is:

Cell number: (_____) _____-_____

Carrier:_____

_____ (***Patient initials***) I consent to emails, to receive communications as stated above.

The **email** that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is: _____.

-I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

**OR**

_____ (***Patient initials***) I choose to opt out of this service and receive phone calls only to confirm my appointments.

Patients Signature: _____Date:_____

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), all medical records and other individually identifiable health information of which we have knowledge must be kept confidential. All personal health information used by us or disclosed by us is covered by this Act regardless of whether this personal health information is in electronic, oral or paper form. Several new rights are granted to patients under this Act, allowing control over how your personal health information is used, how you can access it, and in some cases amend it.

We are required by law to maintain the privacy of your personal health information and to provide you with notice of our legal and privacy practices with respect to your personal health information.

We may be assessed a penalty for any misuse or unauthorized disclosures of your personal health information as regulated by HIPAA.

This Notice of Privacy Practices is effective on July 17, 2010.

We are bound to abide by the terms of this notice and reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

You will be asked to sign a consent form authorizing us to use and disclose your personal health information only for the following purposes, as defined under the Act:

- Treatment means the provision, coordination, or management of health care and related services by one or more healthcare providers, including the coordination or management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for health care from one healthcare provider to another. An example of this would be a dentist referral to an orthodontist.
- Payment means obtaining reimbursement for the provision of health care; determinations of eligibility or coverage; billing; claims management; collection activities; justification of charges; and disclosure to consumer reporting agencies; protected health information relating to the collection of reimbursements (only certain information may be disclosed). An example of this would be submitting your bill for health care services to your insurance company.
- Health care operations are any activity related to covered functions in which we participate in the function of our offices, such as conducting quality assessment activities; protocol development; case management and care coordination; auditing functions; business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; fundraising; and marketing for which an authorization is not required. An example of this would be evaluation customer service given to patients.

We may, without prior consent use or disclose your personal health information to carry out treatment, payment or health care operations:

- Directly to you at your request;
- In an emergency treatment situation, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment, if we are required by law to treat you and attempts to obtain consent are unsuccessful, or if we attempt to obtain consent but are unable, due to barriers of communication, but we determine in our professional opinion that treatment is clearly inferred from the circumstances;
- Pursuant to and in compliance with an authorization signed by you; and
- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree to or prohibit or restrict the use or disclosure. This may be an oral agreement between us and may include a directory maintained at our facility containing specific information allowed by this Act.

We may de-identify your personal health information by using codes or removing all individually identifiable health information.

All other uses and disclosures will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice and will abide by that request. However, exception would be any actions already taken, relying on your authorization prior to revocation notice.

We may contact you to provide appointment reminders or to inform you about treatment alternatives or other health related benefits or services that me be of interest to you. We may also contact you for fundraising purposes.

Under HIPAA, you have the following rights with respect to your protected health information:

- You have the right to request restrictions on certain uses and disclosures of protected health information, including restrictions placed upon disclosure to family members, close personal friends, or any other person you may identify. We are, however, not required to agree with a requested restriction.
- You have the right to receive confidential communications of your protected health information, either directly from us or from us or by alternative means or from alternative locations;
- You have the right to inspect and copy your protected health information;
- You have the right to amend protected health information, however, this request may be denied under certain circumstances;
- You have the right to receive an accounting of disclosures of your protected health information made by us in the six years prior to the date of the accounting request; and
- You have the right to obtain a paper copy of this notice from us, even if you have already agreed to receive the notice electronically.

If you feel your privacy rights or the provisions of this notice of privacy policies have been violated, you have the right to file a formal written complaint. This complaint should be addressed either to the Privacy Officer at our office, or directly to the Department of Health & Human Services, Office of Rights. Both addresses appear below. You will not be retaliated against, in any way, for filing a complaint.

For more information about HIPAA
Or to file a complaint, contact:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington DC 20201
(202) 619-0257
Toll free: (877) 696-6775
Please contact us for more information:

Privacy Officer:

Betzy Ruiz
Affinity Dental Center
14 Gallivan Lane
Uncasville, CT 06382
(860) 367-0688