JOSE M. GARCIA, D.D.S.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
"You May Refuse to Sign This Acknowledgment."

I, ______________________________ have received a copy of this office's Notice of Privacy Practices.
(Please Print Name)

____
(Signature)

____
(Date)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

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 describe 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 copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Uhla Rafiner

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.

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:

Parent or Legal Guardian: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________________ Date: ______________

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

Payment for services are due at the time services are rendered. We accept cash, checks and all major credit cards. Returned checks are subject to additional collection fees. Charges may also be assessed for broken appointments not cancelled within 24 hours.

Your insurance is a contract between you , your employer and the insurance company. Our office will gladly submit insurance forms for you. Please understand the following common insurance practices:

Insurance benefits paid may not cover the office fee charged for some services rendered. Reason: Insurance benefit fee scales (described as "usual", "customary", and "reasonable", etc.) are determined solely by your insurance company and do not reflect actual fees. The delivery of high quality services is not always possible at the "allowable benefit" paid by your insurance.

Insurance benefits for certain services may be denied or paid at a reduced level. Reason: To limit claims liability the insurance companies have treatment exemptions and exclusions based upon their own restrictive criterion or definition of "necessity". Insurance companies and their paid consultants function as dispensers of limited payable benefits. In contrast, our goal is to provide high quality service and promote optimal dental health and function for long term success

We are pleased to work with your insurance company. As contractually agreed between you and the insurance company, the patient copayment is due at the time of service. We are able to wait only up to four weeks for payment from your insurance company. If your insurance delays payment beyond one month, we require that you pay the balance due. If insurance proceeds are later received they will be assigned directly to you.

I hereby ask and authorize payment directly to Dr. Jose Garcia of the group insurance policy otherwise payable to me. It is considered a method of reimbursing for fees paid to the doctor and is not a substitute for full payment. I also authorize the release of any information relating to my claim.

Should it be necessary to collect my account through an attorney or collection agency, I hereby agree to pay all cost of collection, including all attorney's fees, collection cost, and court costs.

I hereby authorize and request the performance of dental services for myself or for my eligible dependents. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his/her supervised staff for diagnostic dental treatment.

We would appreciate your signature below authorizing dental treatment, acknowledging insurance policies and financial responsibility, and your submitted information is correct.

Signature______________________________ Date___________________