**CONSENT & ACKNOWLEDGEMENT TO USE OR DISCLOSE HEALTH INFORMATION**

**FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

*EFFECTIVE 12-01-02*

**PATIENT NAME: .DOB .**

In the course of providing service to you, we create, receive, and store medical information that identifies you. It is often necessary to use and disclose this information in order to treat you, obtain payment for our services, and conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this document. The use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your medical information as may be necessary or appropriate for you to receive follow-up care from another health professional. The use and disclosure of your health information for purposes of payment includes our submission of your medical information to a billing agent for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. We will update our privacy practices as they change. You may obtain an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or preformed health care operations in reliance upon our ability to use or disclose your medical information in accordance with this consent. We can decline to serve you if you elect not to sign this form. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding upon us.

I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

**PATIENT NAME: .DATE: .**

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES FROM HUBBARD DENTAL CARE.

**RELATIONSHIP TO PATIENT IF UNDER 18: .**

**PATIENT/PARENT/GUARDIAN SIGNATURE: .DATE: .**

I authorize Hubbard Dental Care to furnish my personal medical information to insurance carriers, third-party payers or other healthcare providers concerning my diagnosis and treatment. I hereby assign to the physician all payments for medical services rendered to myself or my dependants. I understand that I am responsible for the co-insurance, deductable, co-pay, portion or services not covered by my plan, or denied claims. I am also responsible with providing accurate personal information- including, but not limited to address, telephone numbers, insurance provider or employer information for filing purposes and update information as it changes.

**PATIENT/PARENT/GUARDIAN SIGNATURE: .DATE: .**

Hubbard Dental Care 120 W Bower Harrison, AR 72601 Phone: (870) 741-1050 Fax: (870) 741-1087