Consent/ Privacy Form

-14th Floor Dental is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC & the ADA.

-For my convenience, this office may release my information to my insurance company, and receive payment directly from them. I hereby authorize payment directly to 14th Floor Dental from the insurance benefits otherwise payable to me. Every effort will be made to help me with my insurance, but if they do not pay as ESTIMATED, I will still be responsible.

-If an appointment is broken without a 24 hr notice, 14th Floor Dental reserves the right to charge a broken appointment fee of $50 per hour, which I will be responsible for paying.

-Treatment plans may change, and I will be responsible for work actually done. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary and advisable.

-I understand that I am responsible for all costs and dental treatment. I agree to pay a finance charge of 1.5% per month on any balance 60 days past due, unless acceptable arrangements have been made. In the event my account is sent to collections, I agree to pay all related fees and court costs.

Print Name_____ Signature_____ Date_____

If Patient is Under 18:
Responsible Party_____Relationship to Patient_____

Privacy Practices

Acknowledgment of Notice of Privacy Practice

I, understand that Dr. Larson's Office Abides by the HIPAA law and will protect the privacy of your personal information.

** *You may refuse to sign this acknowledgment***

Please print name_____

Signature_____ Date_____

FOR OFFICE USE ONLY:
We attempted to obtain written acknowledgment for the receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:
____ Individual refused to sign.
____ Communication barriers prohibited us from obtaining acknowledgment.
____ An emergency situation prevented us from obtaining acknowledgment.
____ Other (Please Specify