# Patient HIPAA Consent Form

I understand that I have certain right regarding my protected health information.
These right are given to me under the Heath Insurance Portability and Accountability Act of 1996 (HIPAA) this provides a safeguard to my privacy.

To the best of my knowledge, the information given on the Welcome Forms is complete and correct. I understand that it's my responsible to inform my doctor if I or my minor child ever have a change in health.

I certify that I, and/or my dependent(s) have insurance coverage with the insurance company(ies) listed on the Welcome Forms and assign directly to the doctor also listed on the Welcome Forms all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charged whether or not paid by insurance, I authorize the use of my signature on all insurance submissions.

The Dentist (Doctor) listed on my Welcome Forms may use my health care information and may disclose such information to the insurance and determining insurance benefits payable for services.

I understand that Dentistry, like other medical services are not an exact science that, therefore, reputable practitioners cannot guarantee results. However, the Doctors do guarantee that they will use all of their experience, skills, and technology to provide me with the best dental care. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

PRINT Name of Patient: Date:

---

SIGNATURE of Patient (or Guardian): Date:

---