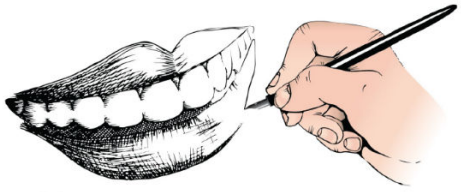

BALTZLY DENTAL

BRINGING ART TO YOUR SMILE

**Patient Name: _____ Date of Birth: _____**

**Consent for Treatment:** I hereby give consent for the dentist(s) and staff of Baltzly Dental to examine and render dental care and treatment to me/the above-named patient. I further authorize Baltzly Dental dentist(s) and staff to perform such diagnostic and treatment procedures and to administer such medications as may be necessary and appropriate for diagnosis and treatment.

**Payment Authorization:** I authorize Baltzly Dental, to release to my insurance company, or other likewise agents any information that is required to process my insurance claim and/or to determine benefits payable for related services. I also authorize Baltzly Dental to utilize a fax machine or email to transmit any or all the records pertaining to my dental care or insurance reimbursement. I acknowledge that faxing and emailing dental records may increase risk of accidental disclosure of my records. I grant permission to Baltzly Dental to release all or part of my dental records to any consulting entity that may be involved in my care including, but not limited to consulting dentist(s) or physicians and labs. I also authorize payment of my dental benefits be made directly to Baltzly Dental on my behalf.

**Guarantee of Payment:** I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, any/all balances not covered by contractual write-off between Baltzly Dental and my third-party payor, and all charges for non-covered services. My insurance carrier's failure to pay does not release me from this responsibility. I understand that if my balance is not paid within 90 days my account will be sent to collections. I also agree that if my account is sent to collections, I will be responsible for all costs associated with debt collection including attorney fees and court costs. I understand that if I cancel my appointment less than 24 hours before the scheduled time, I agree to pay the $50 broken appointment fee.

**Patient Rights and Responsibilities:** I acknowledge that I have seen the Patients' Rights and Responsibilities notice posted at the Baltzly Dental reception area and at baltzlydental.com (copy available upon request), and that I understand my patient rights and responsibilities.

**HIPAA:** I attest to the fact that I have had full opportunity to read and consider the contents of the Notice of Privacy Practices which is posted in the reception area at Baltzly Dental and at baltzlydental.com (copy available upon request).

By signing below, you acknowledge that you have read and understand all the information above. This signed document will remain in effect unless and until you revoke it in writing.

**Patient/Guardian Signature: _____ Date: _____**

Unless you opt out in writing, HIPAA allows the disclosure of a limited amount of your health information to family members, friends, or others you have identified below when you are unavailable, incapacitated or in an emergent condition, and the practice thinks it would be in your best interest to do so. Please select one of the options below:

**My health information may be released to: _____**

**Patient/Guardian Signature: _____ Date: _____**

## OR

**I am electing to opt-out so that no health information is released to family, friends, or others.**

**Patient/Guardian Signature: _____ Date: _____**