Baltzly Dental

Name: _____ Date of Birth: _____

By signing below, you acknowledge that you have read and understand all of the above information, which in summary

Consent for Treatment: I hereby give consent for the dentist(s) and staff of Baltzly Dental to examine me and to render dental care and treatment to 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.

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 of the above dental 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 dental 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 I am referred to, 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, non-covered services, and charges, and any and all balances not covered by contractual write-off between Baltzly Dental and my third party payor. My 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 should my account be turned over to collections, that 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.

includes (but is not limited to) consent for treatment, authorization to release dental information for claims processing, and authorization for our office to receive benefits on your behalf. This signed document will remain in affect unless and until you revoke it in writing.

Patient Signature: _____ Date Signed: _____

Patient Rights and Responsibilities: I acknowledge that I have seen the Patients Rights and Responsibilities notice posted in the front office and that I understand my patient rights and responsibilities.
Initials: _____ Date: _____

HIPAA: I, the undersigned, attest to the fact that I have been informed of the Notice of Privacy Practices (posted in lobby, with copy available upon request) at Baltzly Dental, that are in accordance to all federal HIPAA guidelines.

Signature: _____ Date: _____

HIPAA Notification: 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 release to: _____
Signature: _____ Date: _____

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