East Alabama Pediatric Dentistry

Dr. Keri L. Miller

Consent for Treatment
Assignment of Benefits/Financial Responsibility
Release of Information
Notice of Privacy Practice Acknowledgement

I consent for medical treatment by East Alabama Pediatric Dentistry & Orthodontics to apply for insurance benefits on my behalf for covered Services rendered and I authorize the release of medical information for insurance claims, and release of past medical payment history, if needed. I understand that I am responsible for co-pays, deductibles and co-insurance at the time services are rendered. I also, understand I am responsible for any non-covered services. Patients also are responsible for any collection and legal fees in the events of default.

I authorize the release of any medical information necessary to process my insurance claim. I also, certify that the information I have reported with regard to my insurance coverage is correct.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is federal program that requires that all medical records and health information used by us in any form are kept confidential. This Act, gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for misuse of personal health information. If you wish to review a copy of the **(HIPAA) Privacy Practice** we will be glad to provide you with a copy.
You have the following rights with respect to your Health information.

1. This right to, access, inspect and copy your health information.
2. The right to request an amendment to your health information.
3. The right to receive an accounting of certain disclosures of your health information
4. The right to receive confidential communications.
5. The right to request restrictions on disclosures concerning your health information. ____ (Initial Here)

*****I hereby consent that medical information and treatment can be discussed with the following person or persons. If you want this information only discussed with you leave the following blank. An example would be Spouse, parents etc.

____ ____

____ ____

*****I hereby consent that appointment reminders can be left on answering machine or with a family member.

(Initial) ___________ (HM #) _______________________________(Cell #)_______________________________________

E-mail address ____

Signature of Guardian (must be 18) _______________________________________ Date ___________________

Please list patient that this applies to:

Patient Name ____ Date of Birth ____________________________