CONSENT FOR TREATMENT IN FACILITY

Patient's Name:_____Sex: (F) (M)

Birth Date:_____/_____/_____

Patient's Address:_____

City, State, Zip:_____

Phone:_____

Name of Care Facility:_____

Facility Address:_____

City, State, Zip:_____

Phone:_____

Facility Contact Name:_____Title:_____

In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide health information to carry out treatment, payment of health care operation and for other purposes that we are permitted or required by law.

We will use and disclose your protected health information to provide , coordinate, or manage your dental care and related services. For example: your health/dental information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information periodically to another dentist, physician or health care provider who becomes involved in your care.

We may use and disclose dental information about you in order to obtain payment for services rendered. Such disclosures may me made to you, an insurance company, responsible party or third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.

The Bright Bite
PO BOX 3607 Covina, CA 91722-3607
Call: 626-808-1114
Allison Cuevas
RHD 26799
RDHAP 712

Name of Responsible Party:_____

Phone:_____Fax:_____

Mailing/Billing Address:_____

City, State, Zip:_____

Relationship to Patient:_____

To whom can we thank for referring you to us:_____

_____

Address:_____

City, State, Zip:_____

All fees are ultimately the responsibility of the responsible party.

Permission Granted for Review of Medical Records.

An associate RDHAP may be the provider of the dental hygiene services.

Permission Granted to take pictures of patient for chart identification and educational purposes.

Signature of Responsible

Party:_____Date:_____/_____/_____

Signature of Power of Attorney For Health

Care:_____Date:_____/_____/_____

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