Laurel Laser Dentistry

ACKNOWLEDGEMENT OF PRIVACY PRACTICES & INFORMED CONSENT

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office to obtain a current copy of the *Notice of Privacy Practices*.

- I understand that my signature serves as ***written authorization*** for this office to use my confidential information for the following purposes as pursuant to Maryland State law code 303(b), to renewed annually as required by law.
- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.
- **Payment** means using your health care information to obtain reimbursement for services, confirming insurance coverage, billing or collection activities, and utilization review. A bill may be sent to either you or a third party payer with information that identifies you, your diagnosis, procedures performed and supplies used. For example, we disclose treatment information when billing a dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.
- I authorize the doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make thorough diagnosis of my dental needs.
- Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of possible complications.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by an agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.
- I agree that in the event this account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, cost, expenses and court costs incurred in the collection of this account.

Patient Name: ______________________________ Date: ______________

Signature: ________________________ ***Relationship to Patient:*** ______________

Dependent family members also covered by this acknowledgement and consent:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign ☐ Emergency situation

☐ Communication barriers ☐ Other