Debbie S. Wallace, D.D.S., F.A.G.D.

445 Highway 79
P.O. Box 435
Dover, TN 37058
Tel. (931) 232-8287
Fax (931) 232-2310
wallacedental@lycos.com

PATIENT CONSENT FORM
HIPAA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

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CONSENT

1. I authorize Dr. Debbie S. Wallace and staff to take necessary x-rays, study models, and other diagnostic aids as needed to make a thorough diagnosis.

2. I authorize Dr. Debbie S. Wallace to perform all recommended and agreed upon treatment. I also authorize the use of anesthetics, sedatives, and other medication (as needed) and am fully aware that using anesthetic agents involves certain risks.

3. I authorize Dr. Debbie S. Wallace and staff to use the universal precautions as outlined by OSHA and permit the confidential discussion of my medical history. I consent to HIV and Hepatitis blood testing and documentation for needle sticks and injuries resulting during my care.

4. I am responsible for payment for all services rendered on my behalf and my dependents. I have been informed that payment is due when services are rendered unless other advanced arrangements have been made. I am aware that a 1.5% finance charge is automatically tabulated if my account is 30 days old or older. Should my account become delinquent, I will assume all additional collection costs and legal fees.

_____

Patient or Responsible Party Date

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INSURANCE

1. I authorize Dr. Debbie S. Wallace to release to staff hospitals, health care service plans, insurance companies, self-insurers, or their representatives, any and all information, records and x-rays about my medical history, services rendered and treatment necessary.

2. I authorize Dr. Debbie S. Wallace to submit claims for payment for services rendered for pre-authorizations if necessary to my insurance company, on my behalf and in my names listed as "signature on file" and assign to Dr. Debbie S. Wallace the dental insurance benefits. I understand that I am responsible for payment regardless of the coverage provided.

_____

Patient or Responsible Party Date