CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

FIRST NAME:_____LAST NAME:_____

ADDRESS: _____

TELEPHONE: _____ EMAIL: _____

PATIENT #: _____ SOCIAL SECURITY #: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Content: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain any changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Julia Squire

Telephone: (801) 225-7110 Fax: (801) 225-4001

Email: hilldental@hotmail.com

Address: 205 N State Street, Orem, UT 84057

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative of behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

NOTICE OF REVOCATION:

I, _____, hereby revoke my Consent for use of my protected health information.

Signature: _____ Date: _____

Witness: _____ Date: _____

Hill Family Dental

Jerel D. Hill, DDS
Jared D. Hill, DMD
205 North State Street
Orem, UT 84057
801-225-7110

Financial Policy and Agreement

Thank you for choosing us as your dental provider. We are committed to providing you with excellent patient care. The following is an explanation of our Financial Policy, which you must read and sign prior to any current and future dental evaluation or treatment in this office.

1. Each patient is responsible for his/her own account.
   Patients who have no insurance are required to pay 100% of services at time of treatment. If this is not possible, you will need to make payment arrangements with our office prior to any dental evaluation or treatment. We accept cash, personal check, Visa, MasterCard, American Express, Discover and Care Credit.
2. ***Your dental insurance policy is a contract between you and your insurance carrier.*** We are not a party to that contract. As a courtesy, this office will submit all claims to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding non-payment of your insurance claim(s).
3. You are responsible for knowing what procedures and providers are covered by your dental plan. Any service provided, but not covered by your insurance company will be your responsibility
4. ***If your insurance company has not paid your full account balance within 90 days, you must pay the outstanding balance without further delay.***
5. Payments on accounts billed are expected within 30 days. Delinquent accounts will be charged interest at 1.5% per month.
6. The undersigned specifically agrees to pay all attorneys' fees and court costs in the event that legal action is taken to collect on an account. The undersigned further agrees to pay an additional amount representing up to 40% of the principle balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.
7. Patients who fail to appear for their scheduled appointments ***may be charged*** a $35 missed appointment fee, unless the patient cancels the appointment at least 24 hours prior to their appointment.

Usual and Customary Fees
Our fees for dental services reflect the usual and customary fees in the community. You are responsible for payment regardless of any dental insurance company's arbitrary determination of usual and customary fees for dental services. If our office is a preferred provider with your insurance company, we will abide by their usual and customary rates. However, you will still be responsible for your portion of the bill that they do not pay and for services that are not covered on your policy.

Authorization to Release Information
I hereby authorize this office to release information concerning my dental treatment to my insurance carriers.

Authorization to Pay Benefits
I further authorize and direct said agency, attorney or insurance company to pay from the proceeds of benefits of any recovery or insurance payments in my care, directly to the providers of this office for their professional services rendered. I understand that this in no way relieves me of my personal responsibility for paying my provider when treatment is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

_____ _____

Signature of Responsible Party **Date**

Hill Family Dental

Jerel D. Hill, DDS
Jared D. Hill, DMD
205 North State Street
Orem, UT 84057
801-225-7110

CONSENT TO PROCEED

I authorize Dr. Jerel D. Hill and/or such associates or assistants as s/he my designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including filling of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Holding ones mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may in rare cases, require bronchoscopy or other procedure to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial or serious harm, if any, which may be associate with general preventive and operative treatment procedures in the hopes of obtaining the potential desired results, which may or may not be achieved, for my benefits or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given opportunity to ask questions.

Patient Name: _____

Signature: _____ Date: _____
(Patient, legal guardian or authorized agent of patient)

Witness: _____ Date: _____