PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party ☐ Child

Preferred Name: _____ DOB _____

Responsible Party (if someone other than the patient)

First Name:_____ Last Name: _____ Middle Initial:____

Address: _____ Address 2: _____

City, State, Zip: _____ Email: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Email: _____

Home Phone: _____ Work Phone: _____ Ext: _____Cellular: _____

Sex: Male _____ Female _____ Marital Status: Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow ☐

Birth Date: _____ Age: ____ Soc. Sec:_____ Drivers Lic: _____

Occupation: _____ I would like to receive correspondences via text and e-mail. Y☐ N ☐

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Prev. Dentist: _____

Employer ID:_____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg. _____

Section 3

Emergency Contact: _____

Emergency # _____

Additional Comments: _____

Who should we thank for recommending our office? _____

Primary Insurance Information

Name of Subscriber: _____ Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Child ◯ Other

Subscriber Soc. Sec: _____ Subscriber DOB: _____

Employer: _____

Address: _____

Address 2: _____

City,State,Zip: _____

Member #:_____ Group #: _____

Ins. Company: _____

Address: _____

Address 2: _____

City,State,Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Child ◯ Other

Subscriber Soc. Sec: _____ Subscriber DOB:

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Member #: _____

Group #: _____

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

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PATIENT MEDICAL HEALTH HISTORY

Name: _____ Date of Birth: _____

Primary Physician: _____ Address: _____

Specialist: _____ Date of Last Physical Exam: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Please list any current medications: _____

_____

Do you need to be pre-medicated for dental procedures because of a prosthetic replacement or for another reason? Y N If so, what antibiotic has been prescribed?_____

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Health History	Yes	No	If yes, please explain:
Are you currently under the care of a physician?			
Have you ever been hospitalized or had a major operation?			
Do you take, or have you taken, Phen-fen or Redux?			
Are you on a special diet?			
Do you use tobacco?			
Do you use controlled substances?			
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			
Have you been treated with radiation or chemotherapy?			
Are you taking blood thinners?			

Are you allergic to any of the following? Please check all that apply:							
Aspirin		Penicillin		Codeine		Acrylic	
Metal		Latex		Sulfa Drugs		Local Anesthetics	
Other: _____							

Women, are you:	Yes	No
Pregnant or trying to become pregnant?		
Nursing?		
Taking oral contraceptives?		

(*Continued below*)

Do you have, or have you had, any of the following? Please check all that apply:											
	Y	N		Y	N		Y	N		Y	N
HEART / BLOOD VESSELS			**NERVOUS SYSTEM**			**DIGESTIVE SYSTEM**			**EYES**		
Rheumatic Fever			Stroke			Hepatitis A, B, or C			Visual change		
Heart Attack / Failure			Frequent Headaches			Jaundice			Glaucoma		
Heart Murmur			Epilepsy or Seizures			Ulcers			**NOSE**		
Heart Pacemaker			Numbness / tingling			**URINARY**			Frequent nosebleeds		
Shortness of breath			Dizzyness / fainting			Kidney disease			Sinus problems		
Congenital Heart Disorder			Psychiatric Care			Venereal disease			**THROAT**		
High Blood Pressure			Shingles			Renal Dialysis			Soreness/hoarseness		
Artificial Heart Valve			**RESPIRATORY**			**BLOOD**			Tonsillitis		
Swelling of the Limbs			Tuberculosis			Sickle Cell Disease			**GENERAL**		
Heart surgery			Emphysema			Anemia			Tire easily, weakness		
Chest Pains			Asthma / hay fever			Blood transfusion			Marked weight change		
Irregular Heartbeat			Persistent cough			Hemophilia			Night sweats		
Other: _____			Difficulty breathing while laying down			Hypoglycemia			Persistent fever		
ENDOCRINE			Sleep apnea			Excessive Bleeding			**OTHER**		
Diabetes			**BONE MUSCLES**			Leukemia			AIDS / HIV Positive		
Family history of diabetes			Arthritis / Gout			**SKIN**			Alzheimer's Disease		
Thyroid disease			Artificial Joint			Eruptions (rash) hives			Anaphylaxis		
Other: _____			Pain in Jaw Joints			Change in skin color			Drug Addiction		
			Osteoporosis						Cancer		
									Chemotherapy		
									Radiation Treatments		
									Tumors or Growths		
									Thyroid Disease		

Reviewed by: _____ Date: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient, Parent, or Guardian Date

_____

Print Name

PATIENT DENTAL HEALTH HISTORY

Patient Information

Name: _____ Nickname: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____ Cell: _____

Sex: ☐ Male ☐ Female ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Date of Birth: _____ SSN: _____ Email: _____
Occupation: _____ Emergency Contact: _____

Dental History

Date of last dental exam: _____ Date of last professional cleaning: _____
Previous Dentist: _____ Phone # _____
Notable dental procedures: _____
Referred by: _____
Reason for visit: _____

I routinely see my dentist every:
☐ 3 months ☐ 6 months ☐ 12 months ☐ Other: _____

How often do you brush your teeth? _____
How often do you floss your teeth? _____
What texture toothbrush do you use? ☐ hard ☐ medium ☐ soft

Have you had, or are you currently experiencing, any of the following? Please check all that apply:							
Bad Breath		Grinding Teeth		Sensitivity to Cold		Jaw Pain	
Sensitive Chewing		Sensitive Biting		Sensitivity to Heat		Loose Teeth	
Broken Teeth		Sores or Lesions		Sensitivity to Sweets		Bleeding Gums	
Discolored Teeth		Abscess		Toothache			

Dental History	Yes	No	If yes, please explain:
Do you have all your teeth? If not, which are missing?			
Do you have oral habits which might affect your oral health (i.e. pipe smoking, playing musical instruments, biting fingernails)?			
Do you avoid chewing on one side of your mouth?			
Have you had complications with past dental treatment?			
Have you had trouble getting numb?			
Have you had reactions to local anesthetic?			
Does food get trapped between your teeth?			
Have you ever whitened or bleached your teeth?			
Do you wear a bite appliance?			
Do you snore or wake up frequently during the night?			

Reviewed by: _____ Date: _____

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Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with an accurate medical history before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. Your mouth truly is connected to your health. The patient is an important part of the treatment team. It is important to report any problems or complications you are experiencing so they can be addressed by your dentist. It is equally important to report your medical conditions to us. Certain heart conditions may create a risk of serious or fatal complications. If you have a heart condition or heart murmur, high blood pressure, diabetes, pregnancy, or other health conditions, advise your dentist immediately so she/he can consult with physician if necessary.

Please inform us of all medication you are currently taking on top of any medications that you are allergic to. If you are taking oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes or if you are taking antibiotics.

As with all procedures and surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee you the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally. There are risk and limitations to all procedures. The practice of dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. Complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections.

Some of the more commonly known risks and complications of treatment include, but are not limited to, the following:

1.) Pain, swelling, and discomfort after treatment;

2.) Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist;

3.) Temporary, or, on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste;

4.) Damage to adjacent teeth, restorations or gums;

5.) An altered bite in need of adjustment;

6.) Possible deterioration of your condition which may result in tooth loss;

7.) Jaw fracture;

8.) Allergic reaction to anesthetic or medication;

9.) A root tip, bone fragment or a piece of a dental instrument may be left in your body, and may have to be removed at a later point in time;

10.) If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment;

11.) Infection in need of medication, follow-up procedures or other treatment;

12.) The need for replacement of restorations, implants or other appliances in the future;

13.) Need for follow-up care and treatment, including surgery;

14.) Prolonged numbness.

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Specific Problem Examinations

In the event that a patient requests only a specific problem be addressed (i.e. broken tooth, pain in one area, etc.) this is considered a problem-focused evaluation. X-rays will be taken in this specific area only, and a complete comprehensive examination will not be done. The dentist cannot diagnose problems in other areas of the mouth. Any future treatment of other areas will require additional x-rays and a complete exam. You will not be considered a patient of record unless this examination is completed.

X-Rays

Our office takes the minimum x-rays to allow us to do a thorough exam for each patient. Modern dental x-ray equipment is extremely low dose radiation. Patient will receive a series of intra-oral x-rays. Diagnostic x-rays provide the dentists with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Without these x-rays, we cannot do a complete exam. We may also take photos of our patients as part of their permanent record. We will not release these photos to anyone without your permission.

Minor

We must receive written consent prior to performing any non-emergency procedures on a minor. Grandparents, step-parents, friends, relatives, etc. are not legally allowed to consent to dental procedures. Unless they have been given written consent by the patient or legal guardian, please do not send your child to an appointment alone or with someone else other than yourself unless you have filled out any necessary consent forms prior to the appointment. Otherwise, we may have no choice but to reschedule your child's appointment to another day.

I certify that I read and write English and fully understand this consent. PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM BEFORE SIGNING IT. By signing this form, I am freely giving my consent to allow and authorize the doctor and/or his/her associates to render any treatment deemed necessary, desirable and/or advisable to me, including the administration and/or prescribing of any anesthetic and/or medication.

Patient/legally authorized representative signature	Date
Printed name if signed on behalf of the patient	Relationship

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our changes will be paid by an insurance company.

A service charge of 5.25% per month on the unpaid balance will be charged on all accounts exceeding 45 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suite be instituted hereunder.

I grant permission to you or your assignee, to telephone, email, or text me to discuss this statement or my treatment.

I understand the above information and agree with its contents and agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.

_____ _____

Signature of Patient, Parent, or Guardian Date

Insurance Authorization

☐ By checking this box,
I authorize my insurance company to pay the dentist all benefits rendered.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the dentist or dental entity.

_____ _____

Signature of Patient, Parent, or Guardian Date

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ANNAPOLIS DENTAL CENTER

Missed Appointments / Late Cancellations Policy

Thank you for selecting Annapolis Dental Center for your dental needs. We would like to take this opportunity to inform you of our practice's Missed Appointments / Late Cancellations Policy.

Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed appointments or appointments not cancelled within 24 hours. Effective October 1, 2019, the charge for missed appointments is $50.00 for a single missed appointment / late cancellation Monday through Thursday and $75.00 for a single missed appointment / late cancellation Friday and Saturday. If you cannot make your appointment and our office is informed with advance notice of 24 hours or more, the appointment may be rescheduled without penalty. Excessive abuse of scheduled appointments may result in discharge from the practice.

If you have any questions about this policy, do not hesitate to ask.

_____
Cardholder Name

_____
Patient Name

_____
Email Address

I have read the above and understand that all missed appointment / late cancellation fees which I incur at Annapolis Dental Center are ultimately my responsibility. I authorize Annapolis Dental Center to process payments for missed appointment / late cancellation fees using the credit card information which I have provided.

_____ _____
Signature of Cardholder Date

Patient Acknowledgements, Agreements, and Disclaimer

I, _____, AGREE AND UNDERSTAND TO THE FOLLOWING TERMS OFFERED BY ANNAPOLIS DENTAL CENTER FOR MY DENTAL CARE;

Treatment Plan Estimates: Annapolis Dental Center prepares a Treatment Plan Estimate so that patients can understand the estimated costs of their recommended treatment prior to its start. The Treatment Plan Estimate is a good faith attempt to predict the cost of your treatment based on the facts known to Annapolis Dental Center when the estimate is made. As your treatment progresses, your dentist may determine in consultation with you that different or additional treatment is necessary and your financial responsibility may change.

If you have dental insurance, it is important to understand that your actual insurance benefits may differ from the benefits estimated in your Treatment Plan Estimate. Your Treatment Plan Estimate of insurance benefits is based on information provided by your insurance company and by you. It is an estimate and your insurance benefits may be higher or lower than estimated. In all cases, you are responsible for amounts not covered by your insurance, unless prohibited by law or contractual agreement. In all cases, we encourage patients with insurance to refer to their member handbooks or to call their plan administrators with any questions or concerns related to specific benefits.

Treatment Plans: All dental treatment plan presented to me is a breakdown of dental services that I need to maintain a healthy mouth. All pricing presented to me for such services are guaranteed for thirty (30) days from today.

Predetermination of Insurance Benefits: If you have insurance benefits, you may have the option to seek a Predetermination of Benefits before you proceed with any treatment. Predetermination of Benefits is a process whereby your insurance company or plan administrator tells you in advance of treatment what procedures may be covered by your insurance plan, the amount the insurance company may pay toward those procedures and the amount you may be required to pay. Requesting a Predetermination is like submitting a claim before the dental procedure or service has taken place.

Because the Predetermination comes directly from your insurer or plan administrator, the risk of error as to your coverage is reduced. If your treatment includes extensive or complex services, such as bridges, crowns, dentures or periodontal work, a Predetermination may be particularly helpful to allow you to appropriately budget for the services or discuss any potential alternative treatment that may be available, if necessary.

The Predetermination of Benefits process give you useful information about what services may be covered. However, your insurer will inform you that a Predetermination of Benefits in not a guarantee of coverage. A Predetermination sets forth your expected benefits based on the information available to the insurer at the time the Predetermination is prepared. The Predetermination may not consider, for example, a prior claim submitted by another dentist for services provided to you, changes in your coverage that occur after the Predetermination is made but before the services actually are provided, or the insurance company's subsequent opinion that a condition could have been treated by a less costly alternative to the service provided by your dentist.

The time it takes to receive a Predetermination from your insurance company or plan administrator can vary, from as few as two weeks to as many as eight weeks. The decision to seek a Predetermination of Benefits or to proceed with treatment immediately is your own, unless your plan requires otherwise. Please inform the Office Manager if you would like to request a Predetermination of Benefits from your insurer.

Insurance Estimate: For your convenience, we are happy to submit your dental claims and accept payment from your insurance company. Your insurance contract exists solely between you and your insurance carrier. We cannot be responsible for the limitations and exclusion determined by your participating insurance plan. With that being said, the insurance portion of the treatment plan is only an estimate and does NOT guarantee that your insurance carrier will pay their estimated portion. Your estimated portion will be due at the time of service. If your insurance carrier downgrades your services

or pays a lesser amount according to your coverage then you, the patient will be responsible for the remaining balance due within thirty (30) days of receiving your Explanation of Benefits from your insurance provider. I authorize and request my insurance company pay directly to Annapolis Dental Center. I agree to be responsible for payment in full for all services not paid by insurance company for myself and/or dependents.

Payments Accepted: Cash, Flex Spending, Credit Cards, and Care Credit. All children must be accompanied by a parent during services.

Complications: The risk of complications from medications used/prescribed with general dental treatment include, but are not limited to, drowsiness, lack of awareness and coordination, nausea, allergic reactions, etc. (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any motor vehicle or hazardous device while experiencing side effects of the medications we may prescribe.

Anesthetic: The use of local anesthetic is used for pain control during dental procedures. There are inherent risks and side effects. They include, but are not limited to: swelling, bruising, soreness, elevated blood pressure or pulse, allergic reaction, and altered sensation that may lead to self-injury. Partial or complete numbness may linger after the dental appointment. In rare cases, it can last for an extended time and potentially it can be permanent.

Medication: Any medications dispersed or prescribed are the patient's responsibility to understand before taking. Particular attention should be given to possible allergic reactions, drug interactions with current medications and their specific side effects.

Guarantees: I accept and agree that there are risk and limitations to all procedures. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to allow Annapolis Dental Center to take x-rays and perform an examination on me today.

Notifications: It is the patient's responsibility to notify the dentist and/or staff of Annapolis Dental Center within thirty (30) days of service if there is a problem. Through this notification, we will be able to act on the patient's behalf. Attempts to correct a problem may occur at our office or a referral to another health care practitioner may be warranted. Any concerns past thirty (30) days will be the responsibility of the patient and any services provided will be an additional cost to the patient.

Appointment Cancellation: When an appointment is made, we set aside an allotted time for your procedure. In the event you are unable to give us 24 hour notice, there will be a $50.00 per person cancellation fee charged to your account from Mon. – Thurs. appointments and $75.00 per patient cancellation fee for Friday and Saturday appointments.

Delinquent Accounts: There is a $25.00 charge to your account for any returned check fee. We will submit all checks twice (2x) into your bank for payment. There is an interest of 5.25% per annum that will be charged on any unpaid balance over sixty (60) days. Any accounts over ninety (90) days delinquent will be sent to a collection agency and a collection fee of 35% of the balance will be charged to your account.

Refund Policy: You may discontinue treatment and request a refund from Annapolis Dental Center at any time. Annapolis Dental Center will refund any amount paid for treatment that you did not receive, except when Annapolis Dental Center's policy for Interrupted Services. Patients requiring crown or bridge services may cancel treatment with no charge prior to natural teeth being prepared or altered for the prosthetic. Once tooth preparation occurs, patients are liable for the estimated full cost of the services even if they choose not to complete treatment.

Cash or Check Payment Refunds: Account Holder Refund Request – Upon receipt of a request for a refund, Annapolis Dental Center will confirm all payments by check have cleared the bank (may take up

to 15 business days). Once the credit balance is confirmed, Annapolis Dental Center will issue a refund check within ten (10) business days. All refunds will be processed back to the original form of payment, except cash payments will be refunded by check.

I CERTIFY THAT I HAVE READ AND I UNDERSTAND THE ABOVE INFORMATION. I acknowledge that all my questions have been answered to my satisfaction. You have the right to accept or deny treatment before it is performed. The fee(s) for these services have been explained to me and I accept them as satisfactory. I understand the insurance estimate is not a guarantee of payment and that I am responsible for any difference in payment. By signing this form, I am freely giving my consent to authorize Dr. Dele including the administration and/or prescribing of any anesthetic agents and/or medications. Annapolis Dental Center reserves the right to change or cancel these terms and conditions at any time.

_____ _____

Patient Printed Name: Date

_____ _____

Signature of Patient, Parent, or Guardian: Date

_____ _____

Witness Signature: Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: 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 ("Notice") 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 the 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: Our office administrative team

Telephone: 410-571-5014

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 practice. 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 to 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 Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____