South Bend Children's Dentistry, P.C.
103 S. Eddy Street
South Bend, IN 46617

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Parent/Legal Guardian Name(s): _____

I authorize South Bend Children's Dentistry, P.C. to release my child's appointment dates/times and protected health information, including but not limited to address, phone number, insurance, health-care information and treatment information to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

We would recommend that you list anyone who may bring your child to appointments and the patient is over 18, we would recommend that you list your parent/guardian.

South Bend Children's Dentistry may disclose patient information, insurance, patient records or x-rays to a referring or referred to dental /doctor's office. ☐ **Yes** ☐ **No**

South Bend Children's Dentistry may file with our insurance for services rendered. ☐ **Yes** ☐ **No**

Signature of Parent/Legal Guardian or

Patient (if over 18 years old) _____ **Date** _____

Consent for Use and Disclosure of Health Information

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. 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 is available at your request. We encourage you to read it carefully before signing this Consent.

Right to Revoke: You will have the right to revoke this Consent at any time by giving written notice of your revocation submitted to our office. Please understand that the revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation.

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

My signature below acknowledges that I have received a copy of the Notice of Privacy Practices for South Bend Children's Dentistry, P.C.

Signature of Responsible Party or

Patient (if over 18 years old _____**Date**_____

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy and Consent form but acknowledgment could not be obtained because: ☐ Individual refused to sign

Financial Agreement for South Bend Children's Dentistry, P.C.

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials. All charges you incur for treatment that is provided are your responsibility regardless of your insurance coverage. We do require that the estimated co-payment for treatment be paid at the time of service. We will file your insurance for you. After dental insurance has paid its portion, a statement is sent to the responsible party for the remaining balance. Payment is expected within 15 days of the statement date.

Patients who do not have dental insurance, payment is expected at each visit for services rendered, with the balance to be paid in full within 30 days.

We do accept cash, personal checks, Visa, MasterCard, and Discover.

Signature of Responsible Party_____ **Date** _____