Natural Smiles Dental Care

HIPAA Consent Form

Natural Smiles Dental Care, 3434 Lexington Avenue N, Suite 700, Shoreview MN (651) 483-9800

Patient Name: _____

Patient Phone#: _____

HIPAA – Notice of Privacy Practice

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Natural Smiles Dental Care may use or disclose your health care information. The notice also explains the rights that you are guaranteed under the HIPAA regulations. We are required by the HIPAA privacy rule to distribute this notice to you and obtain acknowledgment that you have received the notice. Signing below indicates that you have received the notice of privacy practice.

Permission to Share Medical Information

My medical and dental information may be obtained and exchanged verbally with:

Name/Relationship: _____

Initials of patient or guardian: ___

Permission to Bill Insurance and Payment Authorization

I understand that I am responsible for payment of services rendered. If insured, I am responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.

In the event of past due balances, any adult authorized on the family account will be contacted, via phone or email, to discuss payment and/or insurance.

Signature: _____ Date: _____