PONZIO DENTAL

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Oak Park, IL 60302

Phone: (708)452-8100

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CONSENT

I hereby authorize the team at Ponzio Dental to perform dental procedures that we have mutually discussed and approved. I also authorize and request the acquisition of photographs and dental radiographs as may be deemed necessary and advisable by the doctor. I authorize these images to be used as medical documentation of my case, for entry into my office chart as a record of care, and assessment of healing progression during the course of treatment. These images may be used for communication with other healthcare providers, insurance companies, or educational purposes. If used for educational purposes, the identity of the patient will not be revealed.

HIPAA CONSENT: I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Ponzio Dental to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of Ponzio Dental.

I have also been informed of and given the right to review and secure a copy of Ponzio Dental's *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Ponzio Dental reserves the right to change the terms of this notice from time to time and that I may contact Ponzio Dental at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that Ponzio Dental is not required to agree to these requested restrictions. However, if Ponzio Dental does agree, they are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

FINANCIAL POLICIES

The office depends upon reimbursement from the patient for the costs incurred for their treatment. All dental services performed must be paid for at the time the services are rendered. I understand that dental services provided to me are charged directly to me and I am personally responsible for payment. If I carry insurance, Ponzio Dental will provide me with an estimate of my portion not paid by my insurance company. I understand that this portion is due at the time services are performed. Further, for treatments in excess of $1000.00, a full or partial deposit must be made prior to the scheduled treatment date. I understand that

(OVER)

Ponzio Dental will do the courtesy of preparing my insurance forms to assist in making collections from my insurance companies. However, Ponzio Dental cannot render services on the assumption that charges will be paid by my insurance company. Therefore, I acknowledge that any treatment fees not covered by my insurance policy are ultimately my responsibility, and failing to meet this responsibility could result in referral to a collection agency or possible legal action at my expense.

ASSIGNMENT OF INSURANCE: I hereby authorize release of any information needed and also authorize my insurance company to pay directly to this office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can be extended for a period of 90 days from the date of patient's examination. I, the undersigned, hereby agree that in the event of default in the payment of any amount due, and if this account is placed with a collection agency for collection or any subsequent legal action, to pay an additional collection fee of 30% of the account balance due, as well as any attorney fees and court costs incurred and permitted by laws governing these transactions. I grant my permission to you, or your assignee, to telephone me at the contact numbers I have provided to discuss matters related to my account or healthcare.

CANCELLATION POLICY: In order to provide quality dental care at affordable fees, it is crucial that patients keep their appointments, or if unable to do so, provide a minimum of 24 hour notice. Our office policy dictates a failed appointment fee of $25 for every appointment that is not kept or is not cancelled within 24 hour notice.

I have read the above consents and conditions and agree to their content.

SIGNED:_____

_____ (relationship to patient if patient is a minor)

DATE:_____

Printed Patient Name:_____