Wayne Hofflich, DDS
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

----------SECTION A: PATIENT GIVING CONSENT

Name:
_____
_____

Social Security Number: _____

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 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 Person: Annine Ruane
Telephone: 914.664.7400 Fax: 914.664.7260
E-mail: info@smileboutique.com
Address: 660 Gramatan Avenue, Fleetwood NY, 10552

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 to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ [**print**], 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.

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:
_____

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** IMPORTANT: READ THIS NOTICE **

OFFICE BILLING POLICY

Payment for today's visit and your future visits are due at the time of treatment. Our office will gladly process all participating plan paperwork and claims for your treatment however, you are required to pay for your financial portion or co-insurance [the amount the insurance company does not cover] before treatment is completed.

A bill will be issued for all balances not received at the time of treatment. A $10 billing fee will be added to all accounts for each mailed statement. The patient is responsible for any and all costs associated with collection of the overdue balance.

OFFICE CANCELLATION POLICY

We request that cancellations be made at least 24 hours in advance. We understand that there may be extraordinary situations, not in the patient's control, where 24-hour notice is not possible – these will be considered. Please note that each visit/appointment time has been especially reserved for just you. **All NO-SHOWS or less-than-24-hour cancellations will be charged a $40 fee – for each hour reserved –** as it is difficult for other patients who previously requested or needed the same appointment time to fill it on such short notice.

INSURANCE

Please present your current dental insurance card to the front desk to be photocopied. If you are a Metlife patient, no card is required.

REFERRALS

If you have been referred to our office by a friend, family member or colleague, please enter their name below. We would like to thank them!

Referred by:

_____

_____

_____

_____(Print Patient's Name)

(Date)

_____

_____ (Patient/Guardian's Signature – must be signed prior to visit with Doctor)

(Date)