PATIENT CONSENT

1.   I authorize SULLIVAN DENTAL PARTNERS to perform all recommended treatment. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.

2.   I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

3.   I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

4.   A $50 missed appointment fee will be charged to my account for all missed appointments or last minute cancellations by me. I am aware that to hold down operating costs, 24 hour notice of cancellation is required.

5.   I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

6.   I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

7.   I authorize SULLIVAN DENTAL PARTNERS to use any photos taken of me and/or my dependents taken at Sullivan Dental Partners for social media and marketing purposes.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: _____   Date_____

Patient's Address: _____

Signature: _____   Relationship: _____   Date: _____

NOTE (MINORS): The parent or legal guardian must complete this form for a minor, provide consent for dental treatment and accompany the child during each dental visit. If the parent or guardian consented to treatment in advance, an authorized individual named on Page 1 may bring the child. Treatment will not be provided for unattended children.

ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY POLICIES

I received a copy of the Notice of Privacy Practices of SULLIVAN DENTAL PARTNERS. I hereby authorize, as indicated by my signature below, SULLIVAN DENTAL PARTNERS to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____   _____
Print Name   Address

_____   _____
Signature   Date

Please check your preferred means of communication:

☐ You may contact me at my house telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an email at _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

                                                                                        (circle)

1. _____   Relationship _____   Date ___/___/___ added / removed

2. _____   Relationship _____   Date ___/___/___ added / removed

3. _____   Relationship _____   Date ___/___/___ added / removed

4. _____   Relationship _____   Date ___/___/___ added / removed

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____