CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name of Patient:_____
Address:_____
Phone: _____

Section B: To the Patient or Their Representative If Patient is a Minor
Please Read the Following Statements Carefully

Purpose of Consent: By signing this form you will consent to our use and disclosure of you r 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 is posted for your review. We encourage you to read it carefully 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 our office:
Phone: 614-527-1000
Fax: 614-527-0100
Address: 3663 Ridge Mill Drive, Hilliard, Ohio 43026
Right to Revoke: You will have the right to revoke this Consent at any time by providing written notice of your revocation submitted to the practice. 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 treatment if you revoke this Consent.

Signature of Patient or Their Representative if Patient is a Minor

I, _____ have had full opportunity to read and consider the contents of this Consent form and your 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 healthcare operations.
Signature:_____ Date:_____

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 continue treatment after I have revoked my Consent.
Signature:_____ Date:_____

You are entitled to a copy of this consent after you sign it at your request. A copy is included in the patient's chart.

Office Policies

Insurance/Billing

As a courtesy, we accept assignment of benefits for primary and secondary insurance. It is your responsibility to provide our office with complete and accurate insurance or billing Information at the time of service. Our office cannot guarantee the amount that an Insurance company will pay. Your insurance is a contract between you and the insurance company and we are not a party to this contract. Disputes with insurance companies are the responsibility of the insured. We have no control over the terms of your contract, the method of reimbursement, or the determination of benefits. You agree to be responsible for payment of all services rendered to your child. We will file a pre-determination for recommended treatment, however any pre-determination is only an estimate of Insurance coverage. Our office will file your Insurance a maximum of two times per appointment.

We request that you pay your estimated portion when services are rendered, Any amount not covered by insurance or any difference In the estimated portion is the parent or guardian's responsibility. For your convenience we accept MasterCard, Visa, Discover, check, cash and Care Credit.

There will be a monthly maintenance fee of $5.00 on account balances over 60 days old. There will be a $30.00 fee for checks returned by the bank.

Responsible Party

Please be aware that the parent or guardian who signs this consent form is legally responsible for payment regardless of whether or not they are the Insurance holder. In the event of separation or divorce, the parent or guardian who signs this form is legally responsible for payment.

We cannot send statements to other parties. Reimbursement must be made between divorced parents. We will not intervene.

Scheduling and Missed Appointments

Patients are seen by appointment only. Arriving on time makes it possible for your child to be seen as scheduled. Patients who are running late are asked to call the office as soon as possible to and see If they will still be able to be seen. We prefer to see preschool age children during the morning hours whenever possible. For school- aged children, we have a limited number of after school appointments available. It may be necessary for your child to miss a portion of their school day. Dental appointments are an excused absence from school. A signed excuse for your child's appointment will be provided upon request.

*Kindly notify us in advance if you are unable to keep an appointment, with **a** minimum of 48 business hours notice. We understand that there are circumstances that may prevent you from keeping your child's appointment. Giving us notice allows us to offer the appointment to other patients awaiting care. We reserve the right to charge a fee of $50 for **any** missed or rescheduled appointment with less then 48 business hours notice.*

Appointments canceled with less than 48 business hours notice on a school holiday or an after school time will not be rescheduled on another school holiday or after school, as they are our most popular appointments.

Past Due Accounts

The office cannot carry balances longer than 60 days; regardless if insurance payment is still pending. If the insurance company does not pay the practice within 60 days, we will look to the responsible party for payment.

If we later receive payment from the insurer, we will refund any overpayment. If payment has not been received after 90 days, we will inform you of the delinquent account and if no action is taken to clear the account, this office will employ a collection service to collect payment. The responsible party agrees to pay a (40% of the total billed amount) fee associated with the collection of the account.

I have read and agree to the above Office Policies

_____

Signature of parent/guardian/responsible party

Date_____ Relationship to patient_____

_____

Name of child (children)