

ACKNOWLEDGEMENT AND AUTHORITY

Name: _____

Date: _____

I consent to treatment as necessary or desirable for the patient named above, including but not restricted to drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending Doctor, staff or qualified designate. I authorize to Michael F. Tillery, D.D.S., PC and Associate release any information to third party payers and/or health practitioners. I authorize and request my insurance company to pay Michael F. Tillery, D.D.S., PC and Associate directly, otherwise payable to me. I understand my insurance carrier may pay less than the total bill for services and unconditionally agree to be responsible for and to pay for any and all charges incurred on my behalf or my dependents. I agree and understand that in the event I do not pay Michael F. Tillery, D.D.S., PC and Associate the balance due, and my account is placed in the hands of a collection agency and/or an Attorney for collection proceedings, I will be legally responsible for all Attorney/Collection fees, court costs, collection costs, consideration for assignment, litigation expenses, as well as any other incidental incurred by Michael F. Tillery, D.D.S., PC and Associate and/or their assignees. I agree to pay Michael F. Tillery, D.D.S., PC and Associate a minimum fee of \$40.00 for any appointment I schedule and fail to arrive for or cancel with less than 24 hours advance notice unless a dire emergency dictates. The information I have given today is correct to the best of my knowledge. I also understand this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my personal and medical status. I authorize the dental personnel to perform any necessary dental services and I may need during my diagnosis and treatment with my informed consent. If the patient is a minor I certify I am the legal guardian.

Patient, Parent or Agent (Must be 18 years older)

Date

HIPAA AWARENESS

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released: To whom may the information be released [name(s) or class(es) of recipients]:The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):Expiration date or event relating to the individual or purpose for the release: It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form. When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority _____