iSmile ORTHODONTICS

Travis W. Wille, DDS, MS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT INFORMATION

Name _____

Address _____

Telephone _____

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 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.

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:

iSmile Orthodontics
Forest Lake North Branch Cambridge
25 Lake Street N, Suite 135
Forest Lake, MN 55025

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 OF RESPONSIBLE PARTY

I, _____ , have had a 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 healthcare 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 _____

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 Note of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my Consent.

Signature _____ Date _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed Consent in the patient's chart

Dental Insurance Information

Patient Name _____

Please complete dental insurance information and sign. For patients covered by more than one dental plan, please complete and sign for each carrier separately.

Name of Insured _____ Relationship to Patient _____
ID OR Social Security Number _____ Date of Birth _____
Dental Insurance Company _____ Group Number _____
Claims Address _____ Phone Number _____
City _____ State _____ Zip Code _____

I hereby authorize the release of any information relating to dental claims for benefits submitted on behalf of myself, and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Dr. Wille to submit claims to my insurance carrier for dental benefits, for services rendered or to be rendered, without obtaining my signature on each individual claim to be submitted for myself and/or dependents.

Signed _____
Dated _____

I hereby authorize payment of dental benefits, otherwise payable to me, directly to Dr. Wille

Signed _____
Dated _____

Name of Insured _____ Relationship to Patient _____
ID OR Social Security Number _____ Date of Birth _____
Dental Insurance Company _____ Group Number _____
Claims Address _____ Phone Number _____
City _____ State _____ Zip Code _____

I hereby authorize the release of any information relating to dental claims for benefits submitted on behalf of myself, and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Dr. Wille to submit claims to my insurance carrier for dental benefits, for services rendered or to be rendered, without obtaining my signature on each individual claim to be submitted for myself and/or dependents.

Signed _____
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Name of Insured _____ Relationship to Patient _____
ID OR Social Security Number _____ Date of Birth _____
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