CONSENT TO USE AND DISCLOSURE OF INFORMATION FOR TREATMENT, PAYMENT OR OPERATIONS:

I acknowledge receipt of the Notice of Privacy Practices(HIPAA), indicating when and where my personal and medical/dental information can and cannot be utilized. I have read this notice or do not wish to read, prior to signing this consent. I understand that a copy of this notice is available to me upon my request. I acknowledge agreement with all parts of the agreement and understand that I can revoke this consent at any time, by notifying Nixa Family Dental Center in writing. I also acknowledge that I can restrict how or to whom my medical/dental records are used or disclosed and that this must be done in writing and accepted by Nixa Family Dental Center

INSURANCE POLICY:

I understand that Nixa Family Dental Center will, upon request, attempt to obtain dental insurance information for me. All insurance information provided is just an estimate. However, I realize that, regardless of dental insurance, the account is ultimately my responsibility should the insurance not process my claims as estimated.

CANCELLATION POLICY:

I understand that a 24-hour notice is required for any cancellations. Cancellations without a 24-hour notice could be subject to a $25.00 cancellation fee.

GENERAL ACKNOWLEDGEMENTS/POLICY FOR OFFICE:

To the best of my knowledge, the information provided is accurate. I understand that, if my account is referred to a collection agency or there is need for a law suit, I will be responsible for all collection fees as well as attorney fees and court costs.

AUTHORIZATION FOR TREATMENT:

I, the patient or the responsible party for this patient, authorize for treatment to be performed today and into the future until permission has been revoked in writing.

SIGNED: