Patient Consent and Acknowledgement

HIPAA

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and referrals.

Our notice provides a description of our treatment, payment activities and healthcare operations. In addition, it provides the uses and disclosures we may make of your protected health information. Your signature below is also your consent to treatment at Dental Arts of Corinth, PLLC.

I understand that I may revoke this consent in writing at any time.

______________________________ specifically has my written consent to call and make appointments, discuss treatment plans and account balances. (This is anyone close to you that you wish to have this information.)

______________________________ ________ ______________________________

Patient/Guardian Signature: Date: Relationship to Patient:

Phone: (662) 287 - 3156
Fax: (662) 287 - 3157
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