ADVANCE
DENTAL
CARE

*Cosmetic & Family Dentistry-Specialists on Site*
*Sherry Maz, DMD*
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# Consent for Disclosure

With my permission, Advance Dental Care may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Advance Dental Care Notice of Privacy Practice for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices for a more complete description of such uses and disclosures. With my permission, the office of Advance Dental Care may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my pertaining to my clinical care, including laboratory results among others. With my permission, the office of Advance Dental Care mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statements as long as they are marked Personal and or Confidential. With my permission, the office of Advance Dental Care may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Advance Dental Care Restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement. By signing this, I am allowing Advance Dental Care to use and disclosure my PHI for TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

# Consent for Treatment

I hereby authorize doctors of Advance Dental Care to take, use and disclosure of x-rays, study models, photographs, written or electronic health records, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs, payment and health care operations. Upon such diagnosis, I authorize the doctors to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications, and that only the minimum amount of information necessary to provide quality care will be used and that a notice fully outlining the protection of my personal health information is available upon request. I, acting as the responsible party for my child, give my consent to Advance Dental Care to provide any necessary dental treatment for him/her. The medical history for the patient has been reviewed and signed by me, and is correct to the best of my knowledge. I agree to be responsible for payment of all services rendered on my behalf or of my dependents by Cash, MasterCard, Visa, American Express, Discover, Debit Card, and Care credit. If required, I also understand a check of my credit history may be made. Refunds for any pre-paid procedures are subject to Credit Card fees (3% to 5%) or Care credit/third party financing fees (5% to 18%). In the event payments are not received by agreed upon dates, a 1-1 ½% monthly late charge (18% APR) may be added or my account will be referred to a collection agency and I will be responsible for collection fees incurred. If my collection case is taken to court, I will be responsible for all legal fees and court costs. Office policy requires 2 business days notification for all cancellations. If my appointment is not cancelled within the required notice, there may be a $50 charge per hour. At this time, we are participating providers with several insurance companies. I authorize the office to affix my name to any and all documents as related to any and all health benefits due me and my dependents through my employment. I hereby authorize payment of dental benefits directly to the office. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for the dental services and materials not paid by dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan, prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim. This “authorization” will be valid from this date and shall renew annually unless I cancel in writing. A photocopy of this document may act as an original.

| **Name** | **Signature** | **Date** |
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