Burstein Dental

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Burstein Dental. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check to indicate your approval:

☐ You may leave message(s) on my home phone.

☐ You may leave message(s) on my cell phone.

☐ You may contact me on my work phone number.

☐ You may leave message(s) for me at my work.

☐ You may send me postcards or email(s) related but not limited to, my upcoming appointments, office promotions, special announcements or other relevant healthcare information.

Please list authorized persons with whom we may discuss your or your child's Protected Health Information (PHI), separate from custodial parents and/or legal guardians:

1. _____ Date Added / Removed:_____ Phone # _____

2. _____ Date Added / Removed:_____ Phone # _____

3. _____ Date Added / Removed:_____ Phone # _____

4._____Date Added / Removed:_____ Phone # _____

5._____Date Added / Removed:_____ Phone # _____

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For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____

PATIENT / PARENT GUARDIAN CONSENT

Clinical

1. I authorize Burstein Dental to perform all recommended treatment on **myself** / **my minor child** (indicate one) _____.
   PATIENT NAME

2. I authorize the Practice to take radiographs, study models, digital photographs and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.

3. I authorize the use of anesthetics, sedatives, and other medications, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Insurance

4. I authorize the Practice to release to other dental or healthcare providers, hospitals, health insurance companies, or any of their such designated representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

5. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: _____ Date: _____

Signature of Patient/Parent or Guardian: _____

Relationship to Patient: _____