

Patient HIPAA Consent Form

Stonebridge Dental
781 Far Hills Drive, Suite #500
New Freedom, PA 17349
(717) 235-8234

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you, Stonebridge Dental, to use and disclose my protected health information to carry out the following:

- *Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);*
- *Obtaining payment from third party payer (e.g. My insurance company);*
- *The day-to-day healthcare operations of Stonebridge Dental's healthcare practice*

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operation, and that you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature of Patient: _____ Date: _____

Print Patient's Name: _____

Relationship to Patient: _____

Cancellation Policy

Upon scheduling appointments, we have reserved this time especially for you. If you are unable to keep this appointment, please give a minimum of 24 hour notice. Be advised that there may be a charge for the missed appointment.

Please also be advised that our courtesy text reminders and email communications are not to be used for cancelling appointments. These courtesy reminders are opted in or out directly by the patient.

Signature of Patient: _____ Date: _____

Print Patient's Name: _____

Relationship to Patient: _____