Smile 4 Life Dental, P.C.

HIPAA – Health Insurance Portability and Accountability Act.

Patient Rights
This new law is careful to describe that you have the following rights related to your health information.

Restrictions
You have the right to request restrictions on certain uses and disclosures of your health information.

Confidential Communications
You have the right to request that we communicate with you in a certain way. You may request we only communicate your health information privately with no other family members present or through mailed communications that are sealed.

Inspect and Copy your Health Information
You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records.

Amend your Health Information
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. Your request may be denied if the health information record in question was not created by our office.

Documentation of Health Information
You have the right to ask for a description of how and where your health information was used by our office at any time. You have the right to express complaints to us or to the Security of Health and Human Services if you believe your privacy rights have been compromised.

Smile 4 Life Dental agrees to treat you to the best of their abilities and acknowledges your choice as their guest, and supports your rights as a client/patient.

Client Signature: ____ Date: _____________________

I understand the procedures today were performed by a dental hygienist. I understand that therapies and information offered by my hygienist shall not be construed to be a diagnosis or treatment of any specific disease or injury. I understand that I am advised by my hygienist to consult my physician and dentist for diagnosis. I further realize that I have the right to ask for clarification when necessary and that my questions will be answered to my satisfaction. I therefore consent to services mutually agreed upon so that treatment can be completed. I also consent to any emergency care that is necessary. I further understand and agree to hold harmless, Smile 4 Life Dental as well as all its employees.

I understand clearly that in order to maintain the optimal dental health of (myself) or my dependant _________________________, I have been advised of the need to see a dentist at least once a year for the diagnosis of any necessary dental restorative or surgical procedures.

Insurance Consent
I authorize Smile 4 Life Dental to contact or bill my insurance company for services rendered. I understand that I will be financially responsible for services or portion of services not covered by my insurance company.

Client Signature: ____ Date: ____________________