PECHEK DENTAL & associates

PATIENT AND HIPAA CONSENT FORM

We comply with the law covering medical identity theft, therefore we require you to verify identification when you check in for dental services. We ask that you bring one current photo/picture identification issued by a local, state or federal government agency to your appointment, as well as a copy of your current DENTAL insurance card.

- Current Driver's License
- State ID
- Military ID
- Current Passport

Please notify us at least 24 hours in advance if you need to reschedule or cancel your appointment. We cannot accommodate patients who fail to keep their appointments.

Your first appointment is an initial assessment examination which does not include treatment. Please bring your insurance card, picture identification and completed Patient Information Form. There may be a fee of approximately $100 for this appointment for x-rays and exam. If you have had dental x-rays within the last six months, you will need to have your x-rays sent to admin@pechekdental.com. A thorough oral evaluation, plan(s) of proposed treatment and fees will be discussed with you at your appointment.

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

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of the practice.

I have also been informed of, and given the right to review and secure a copy of our Notice of Policy Practices, which contains a more complete description of how my information may be used and 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 most 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 operations, but that you are bound to comply with this restriction.

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

Print Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____