Stanislaus Oral Surgery and Implantology

Oral and Maxillofacial Surgery

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Consent to the Use and Disclosure of Health Information

Name/please PRINT: _____

Date of birth:_____SSN: _____

I understand that as a part of my healthcare, the offices of Dr. Elder and Dr. Roth originates and maintains health records describing my health history, examinations and test results, diagnoses, treatment and any plans for future care treatment.

I understand that The Notice of Privacy Practices information serves as:

- A basis for planning my care and treatment
- A means of communication amongst the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

❒ I request the following restrictions to the use or disclosure of my health information:

Medical information can be discussed with:

- ❒ Patient Only
- ❒ Family member and/or friend: _____
- ❒ Physician
- ❒ Other: _____

Detailed messages regarding test results can be left on my answering machine/voicemail:

❒ Yes ❒ No Phone#: _____

❒ Other restrictions:_____

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices for Dr. Elder and Dr. Roth.

SIGNATURE: _____DATE: _____

PAYMENT POLICY

INSURANCE PATIENTS: Due to the overwhelming number of insurance companies and their different policies, it is impossible for us to give you a true estimate of the proposed insurance reimbursement. In order to bill your insurance company we must have your insurance information, including the mailing address and your ID number. Your insurance policy is a contract between you and your insurance company. You are responsible for knowing the benefits of your individual plan. We are willing to pre-authorize the proposed treatment in writing, which usually delays surgery for 6-8 weeks. It is your responsibility to pay for services not covered by your insurance company.

NON-INSURANCE PATIENTS: Payment in full is expected at the time of service unless other financial arrangements have been made.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: _____DATE: _____