# BRODIE OAKS DENTAL CLINIC

## ***CONSENT***

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (name of patient)_____ and further authorize and consent that Doctor may choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

Responsible party:_____Signature:_____Date:_____

Witness:_____Signature:_____Date:_____

## ***FINANCIAL POLICY***

The staff of Brodie Oaks Dental Clinic is dedicated to assisting you achieve and maintain your oral health. As a courtesy to our patients, we will file your insurance claims. In order to file your claim we must have a copy of your current insurance card. If you do not have a current insurance card, full payment is due at the time of service.
**Please note:** We file claims with many different insurance companies and it is impossible to know each individual policy. It is your responsibility to know the rules and benefits of your policy. Please be aware that your insurance company may consider some or possibly all treatment as non-covered services. You are responsible for all fees not covered by your insurance company.
**It is your responsibility to inform us if your insurance information has changed.**

Name:_____Signature:_____Date:_____

## ***HIPAA POLICY***

Please be advised that Brodie Oaks Dental Clinic operates in accordance with the Health Insurance Portability and Accountability Act. As such, your protected health information may be used and disclosed by your dentist, the staff, and others outside the clinic who are involved in your care and treatment for the purpose of providing health care services, to pay your bill, to support the operation of the dental practice, and any other use required by law. You have the right to review and request changes to your health information. You may also request restrictions on the use of your health information. The provider must agree to any amendments to your record or restrictions in the use of your information. If the request is denied, you have the right to file a formal complaint with the Secretary of Health and Human Services.

Name:_____Signature:_____Date:_____

## Cancellation Policy

Appointments canceled or rescheduled with less then a 24 hour notice will result in a charge of $40. Initials:_____