PATIENT CONSENT FORM

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 (HIPPA). 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 your 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 HIPPA. 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 most current copy of the 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 healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, 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 that date I revoke this consent is not affected.

_____ Initial I understand that if I miss three scheduled appointments, I will be terminated as a patient and will need to continue my treatment elsewhere. I understand that these three missed appointments will be reported to my insurance so that action can be taken by them.

_____ Initial I understand that if, in any way, my demeanor or actions are unfavorable or uncalled for, I can be terminated immediately as a patient and will need to continue my treatment elsewhere.

Signed this_____day of _____, 20_____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Hometown Dental
1901 W. Irving Blvd.
Irving, TX 75061
PH: 972-870-5800
FAX: 972-953-0201

Hometown Dental
3515 Sycamore School Rd.
Suite 170
Fort Worth, TX 76133
PH: 817-927-8500
FAX: 817-927-8508

Hometown Dental
6332 Lake Worth Blvd.
Lake Worth, TX 76135
PH: 817-237-3222
FAX: 817-237-0101

Hometown Dental
8620 Skillman St.
Dallas, TX 75243
PH: 214-341-0900
FAX: 214-580-5202

Hometown Dental
1030 W. Arkansas ln.
Suite 210
Arlington, TX 76013
PH: 817-543-2222
FAX: 817-543-2299

Hometown Dental
4224 Gus Thomasson Rd.
Suite A
Mesquite, TX 75150
PH: 972-698-6685
FAX: 972-698-6688

Hometown Dental
3819 Hwy. 75 North
Suite 100
Sherman, TX 75090
PH: 903-813-4867
FAX: 903-868-2032