PRIVACY CONSENT

This form is required by the new privacy regulations issued by the United States Department of Health and Human Services. Prior to commencing your orthodontic treatment, you must review, sign and date this form.

Your Protected Health information (i.e., individually identifiable information such as names, dates, phone numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office privacy notice prior to signing this consent form.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the privacy notice at any time. If we do, we will post a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this consent.

Thank you for your cooperation. Please let us know if you have any questions.

PATIENT CONSENT

I Authorize Image Orthodontics to perform all recommended treatment.

I authorize the practice to take Diagnostic Material, as needed to make a thorough diagnosis. I authorize that such Materials may be released to third-party payers and /or other health professionals.

I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as “signature on file” and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless coverage provided.

I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. Should my account become delinquent, I will be responsible for all additional collection cost, including **$25 no show fee** and attorney fees.

I have read this Privacy and Patient Consent and agree to all the terms and conditions herein

Name_____

Date_____