Citrus Dental of Inverness

This form must be completed by the patient, a parent, or guardian if the person is a minor under state law.

Consent/Authorization for Dental Treatment and Disclosure of Information

Name____

Date of Birth___________________________

Dependent(s) authorized for treatment: ____
____
____
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1. I authorize Citrus Dental of Inverness, P.A. to take necessary radiographs, study models, photos, and other diagnostic measures to make a thorough diagnosis of the identified patient(s') dental needs.

2. I understand that treatment recommendations subsequent to any examination will be explained, and that any ensuing procedures will include patient/parent/guardian agreement and consent.

3. I understand that I am responsible for payment at the time of service. If I have insurance, I understand that I am responsible at the time of service for the estimated balance not covered by insurance. Any payment arrangement is only by previous authorization.

I hereby authorize Citrus Dental of Inverness to release minimum personal health information for:

- ☐ Dental services claims information
- ☐ Prescription, diagnostic, treatment, and/or care management services
- ☐ Reviews required by HHS or HIPAA-compliant health care operations

The above information may be released by/to:
__ Phone __ Fax __ Mail __ Friend or Relative Name(s): ____
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____
____

Other _______________________________

Citrus Dental of Inverness may contact me regarding appointments or other treatment related issues by:

- ☐ Home Phone (# _____________________________)
- ☐ Work Phone (#______________________________)
- ☐ Cell Phone (#_______________________________)
- ☐ eMail (Address: ____)
- ☐ Mail
- ☐ Other (Specify: ____)

I want this consent to: __ Continue Indefinitely __ Effective Until _________________________________

I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Signature of Patient/Parent/Representative ____

Effective Date______________