

RESPONSIBLE PARTY INFORMATION (MINORS MAY NOT SIGN FOR CONSENT)

(MUST BE 18 OR OLDER)

The following is for: ☐ the patient, ☐ the patient's spouse, ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female

☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street

Apartment #

City

State

Zip Code

NOTICE OF PRIVACY PRACTICES

HIPPA Requirements

The Practice:

- (a) Is required by federal law to maintain the privacy of your PHI (Protected Health Information) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- (b) Under the Privacy Rule, The Practice may be required by State Law to grant greater access to maintain greater restrictions on the use or release of our PHI than that which is provided for under federal law.
- (c) Is required to abide by the terms of this Privacy Notice.
- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- (e) Will distribute any revised Privacy Notice to you prior to implementation.
- (f) Will not retaliate for filing a complaint.

Effective date: This notice is in effect as of 10/17/11.

Patient acknowledgement:

By signing my name below, I acknowledge a receipt of a copy of this notice and my understanding and agreement to its terms.

Patient or Guardian

Signature _____ Date _____

TREATMENT PLAN RELEASE

I authorize Advantage Dental to perform the necessary treatment plan.

Patient or Guardian Signature _____ Date _____