

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 Accounting Act of 1996 (HIPAA). 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 unformed 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 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 pf this 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 health care 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 the date I revoke this consent is not affected.

Signed this _____ day of _____ 20 ____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Amazing Smiles
14090 S.W. Freeway, Suite 402
Sugar Land, Texas 77478

AMAZING SMILES, PLLC
14090 S W Freeway, Ste 402
Sugar Land, Texas 77478
281-240-8080
Fax 281-240-5055

Effective immediately, all patients will be required to notify our office at least **24 HOURS in advance** regarding appointment cancellation or rescheduling.

Amazing Smiles is happy to announce that we are growing. We would like to thank all of you who have referred friends or relatives. We want to have time for each of you and reserve your appointment time in advance.

Due to our growing dental family, it has become very important that our patients take their reserved time in perspective. We respect that emergencies and/or illnesses occur that prevent you from keeping your scheduled appointment. Please take a moment to contact us as soon as possible.

Patients who have not shown or cancelled appointments repeatedly without a 24 hour notification will be charged \$25.00. This fee will be collected at the time you receive services. Thank you for your cooperation in this matter.

Should you require further assistance, please do not hesitate to contact us. Someone will be happy to assist you. Thank you for making Amazing Smiles your dental home.

Patient Signature:

X _____

Date: _____