[redacted]

John L. Waldman, DMD

AUTHORIZATION FOR SIGNATURE ON FILE

I, hereby authorize the office to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office. This "Signature On File" will be valid from this date and shall expire afterwards upon my written request. A photocopy of this document may act as an original.

MINOR/CHILD CONSENT

I, being the parent or guardian of _____do hereby request and authorize the dental staff to perform necessary dental services for my child, but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also do hereby authorize the following named adults authority to make dental care decisions and receive information for the above-mentioned minor in my absence:

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- ☐ I have received a copy or given an opportunity to review this office's Notice of Privacy Practices on this date:
- ☐ Patient refuses to sign this acknowledgement.
- ☐ Communication barriers prohibited obtaining acknowledgement
- ☐ Emergency situation prevented us from obtaining acknowledgement
- ☐ Other: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I understand by signing this form, I will consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. Your office will continue to use my health information in some of these ways: by calling me by my first and last name from your waiting room, by posting patient pictures, by making photographs, by mailing me reminder appointment cards with reason for visit, by reminding patients needing a premedication on reminder cards or confirmation calls or leaving messages on my phone answering service, by calling to confirm appointments, and internal audits of patients charts for practice evaluation purposes as described in our Notice of Privacy Practices. *You have the right to request alternative means of delivery.*

☐ You can also disclose my personal health information to the following people: _____

_____ _____ _____

FINANCIAL AGREEMENT

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed can/will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future account balance.

I understand that in order to avoid a missed appointment 24 hour cancellation notice must be given.

Insurance is a contract between you and the insurance company. We file claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, "usual and customary" charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account.

_____ **Patient/Guardian** _____ **Date**