DREAMWORKS
DENTAL & ORTHODONTICS

Health Insurance Portability Act Acknowledgement Form (HIPAA)

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 Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize **Dreamworks Dental and Orthodontics** 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);
- Obtain payment from third party payers (e.g. my insurance company); and,
- The day-to-day healthcare operations of your practice.

I have also been informed of, and have been given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more completed description of the uses and disclosures of my protected health information, and my rights under HIPAA. 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 of the 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 healthcare 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.

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly
(Name of Insurance Company(ies))
to **Dreamworks Dental and Orthodontics** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

I understand that I am responsible for my balance if any of the following occur: *(please initial)*

A. _____The treatment that is proposed is more than my annual maximum.
B. _____My insurance denies any treatment.
C. _____I am not eligible for dental benefits.
D. _____I prevent or delay payment by not complying with the requirements of signatures on forms or any documents required by my insurance or doctor's office.
E. _____I do not finish my treatment and as a result my insurance does not pay for my treatment,
F. _____Lab fees that may accumulate for missing my appointments
G. _____I receive an insurance check for the services that were rendered and I did not forward it to the dental office.

If my insurance has not paid my dental claim after 30 days of services rendered, it is my responsibility to call the insurance carrier and see why they have not paid my claim.

I accept all treatment that has been proposed and authorize that any information that is necessary regarding this dental claim. I understand the policy of **Dreamworks Dental and Orthodontics** regarding my insurance and my responsibility for the service that were rendered. I have read and understand my duties to accept my insurance for payment for my dental services.

_____ _____
Signature of Patient, Guardian or Personal Representative Date

_____ _____
Print name of Patient, Parent, Guardian or Personal Representative Date

Payment is due in full at time of treatment unless prior arrangements have been approved.