DR. JEFFERSON CLARK
IMPLANT DENTISTRY & PROSTHODONTICS

Patient Name _____ Date _____

I have received the following documents:

_____ Initial - Facts About Fillings

_____ Initial - Notice of Privacy Practices

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be payable directly to the undersigned dentist and I am financially responsible for non-covered services. Delta Dental payments will be mailed directly to the policy holder of the insurance and I am financially responsible for the full amount.

_____ Signature of Patient, Parent or Guardian

PHOTOGRAPHY CONSENT

I, give my consent to Jefferson L. Clark, DDS, MS and his staff to take radiographs of dentition and/or photographs of the head and neck areas, including the profile, face, teeth, smile, and intraoral features, pre-, during, and post-treatment for the purposes of internal office use in dental records or for use in treatment planning, education, publication in professional journals, and/or advertising. I understand that my identity will be blurred in most cases and that my personal information will be protected.

I hereby waive any right that I may have to inspect or approve the finished product(s) and advertising copy to which the photographs may be applied.

I have a right to restrict the use of photographic images as indicated here:

_____

_____ Signature of Patient, Parent or Guardian

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released: CLAIM INFORMATION AND PROFESSIONAL CORRESPONENCE AND XRAYS WITH OTHER TREATMENT PROVIDERS
2. The purpose(s) for the release: TO ALLOW FOR COORDINATION OF CARE AND INSURANCE CLAIM PROCESSING
3. Expiration date or event relating to the individual or purpose for the release: UPON TERMINATION OF CARE, UNLESS OTHERWISE REQUESTED BY PATIENT

It is completely your decision to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____ Signature of Patient, Parent or Guardian

APPOINTMENTS

AT LEAST 24 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS ABSOLUTELY NECESSARY. OTHERWISE A CANCELLATION CHARGE OF $50.00 WILL BE ASSESSED.

_____ Signature of Patient, Parent or Guardian