Sorenson Dental **14688 Everton Ave N Suite 104 * Hugo, MN 55038** **(651) 201-0201**

AUTHORIZATIONS AND CONSENT

APPOINTMENTS-

In order to provide each patient with the individual care and attention that they deserve, we ask that you arrive on time for scheduled dental appointments, or fifteen (15) minutes early if indicated by staff. We work very hard to see each patient at their scheduled appointment time. Due to the nature of dentistry; however, unforeseen difficulties or emergencies can arise. We ask for your patience if we are delayed in seeing you or your family member due to treating another patient on an emergency basis. We require twenty-four (24) hours notice if you must change a scheduled dental appointment. Less than 24 hours notice, or not showing up for an appointment, is considered a missed/broken appointment. Missing an appointment is counterproductive for both the patient and our office. A fee of $50.00, or more, depending on the length of time allotted, may be assessed for each missed appointment. After missing three (3) scheduled appointments patients will be placed on a will call list for 3 consecutive appointments.

PAYMENT-

Payment can be made via cash, check, or credit card. We accept all major credit cards. If paying in cash, please bring the exact amount, we usually do not have change. Fees for any treatment diagnosed will be discussed with you at your initial appointment. All emergency dental services and any dental services performed without previous financial arrangements must be paid in full at the time services are rendered. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts with the balance exceeding sixty (60) days, unless previously written financial arrangements are agreed upon.

INSURANCE-

Please provide the front office staff with your insurance card so that we can contact your insurance company regarding your benefits. Please understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment. We will file your insurance claims and work with your insurance company concerning their portion of the treatment fees. Their portion will be credited to your account, Remember, even if you have insurance coverage, you are responsible for the payment of your account.

PHOTO RELEASE-

I, the undersigned, do hereby relinquish any and all rights to photographs, portraits, transparencies, negatives, prints, Polaroid or other photographic reproductions captured with still, motion picture, video, digital, or other cameras for use by this office.

CONSENT FOR DENTAL TREATMENT-

I request and authorize Sorenson Dental and staff to examine, clean, and provide dental treatment for me and my family members. I further request and authorize the taking of dental radiographs as ordered by the treating provider to diagnose and/or treat any dental problem. I will allow Photographs to be taken of my/or my family member's teeth for diagnostic or educational purposes. I grant permission to you or your assignee, to telephone me to discuss matters related to this form.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature: _____ Date: _____

Relationship to patient: _____

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PATIENT HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health and dental history, symptoms, examinations, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as: 1. A basis for planning my care and treatment 2. A means of communication among many health professionals who contribute to my care 3. A source of information for applying my diagnosis and surgical information to my bill 4. A means by which a third-party payer can verify that services billed were actually provided 5. A tool for routine healthcare operations such as assessing quality and reviewing the competence of the healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices at any time and will notify me via mail of the changes to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Print Patient Name: _____ Date: _____

Patient Signature or Representative: _____

Relationship to Patient: _____

Permission to Share Medical Information:

My medical information and financial information may be obtained and exchanged verbally to:

Name: _____ Relationship to Patient: _____