Millbrae Orthodontics
Alan D. Marcus, D.D.S., M.S.D.

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

(ADULT)

I have received a copy of the Notice of Privacy Practices of **Millbrae Orthodontics.** I hereby authorize, as indicated by my signature below, **Millbrae Orthodontics** to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an email at: _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date: Added / Removed: _____

2. _____ Date: Added / Removed: _____

3. _____ Date: Added / Removed: _____

4._____ Date: Added / Removed: _____

* * *

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____

PATIENT CONSENT (ADULT)

Clinical

1. I authorize **Millbrae Orthodontics** to perform all recommended treatment.

2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.

3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

4. A $25-$125 missed appointment fee will be charged to my account for all missed appointments or last minute cancellations by me. This fee is based on the length of my scheduled appointment. I am aware that to hold down operating costs, 48 hours notice of cancellation is required.

Insurance

5. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

6. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: _____

Patient's Signature: _____ Date: _____