WILLIAMSON
family dentistry

CONSENT

I attest to the accuracy of the information on this registration form.

I authorize Dr. Williamson to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize payment of insurance benefits directly to Williamson Family Dentistry, otherwise payable to me. I understand that my dental insurance is a contract between me and the insurance carrier, not between the insurance carrier and Williamson Family Dentistry and that I am fully responsible for all dental fees. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid in whole or in part by my dental insurance carrier.

Fees are due and payable at the time service is rendered unless prior financial arrangements have been made. I agree to pay a finance charge (1.5% per month) for any balance remaining on my account 30 days after treatment. I agree to contact the office if I need to reschedule an appointment. I understand I will be charge a $38 fee if I miss an appointment and do not contact the office at least 24 hours in advance of the scheduled time.

The purpose of the following information is to obtain an individual's written permission under Wisconsin law for (a) our use of the individual's patient health care records, HIV test results, and mental health treatment records to carry out treatment, payment activities, and health care operations, and (b) our disclosure of the individual's patient health care records to carry out treatment, payment activities, and health care operations. This form should not be used to obtain written permission for the disclosure of mental health treatment records or HIV test results unless the name of the recipient is listed on this form.

Individual Giving Consent

Name: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Privacy Practices Notice: You have the right to read our Privacy Practices Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

The Uses and Disclosures Being Authorized

Our Use of Dental Information: By signing this form, you will consent to our use of your patient health care records, treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

Persons Involved in Care: By signing this form, you will consent to our use of your dental care records to the following persons, including those involved in your care or payment for that care. Please list any additional person(s) you would like involved in your care or payment for that care.

_____ _____

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Our Disclosure of Medical Information: By signing this form, you will consent to our disclosure of your dental care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice, and to our disclosure of your dental records for disaster relief purposes as permitted by law.

Revocation

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the Contact Person listed below. Revocation of this consent will *not* affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

Contact Person: Tenley Williamson (262) 567-7400

INDIVIDUAL'S SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am confirming my written permission for the disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

If this consent is signed by a personal representative/parent on behalf of the individual, complete the following:

Personal Representative's Name: _____ Relationship to Individual: _____