Fusco Family Dentistry
Office of Adam D. Fusco, DMD

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 Fusco Family Dentistry. I hereby authorize, as indicated by my signature below, 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: _____

May we contact and thank the person responsible for recommending you to our office? YES / NO

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

Clinical

1. I authorize Dr. Adam D. Fusco to perform 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 – No Dental Insurance

I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

Financial – Dental Insurance

We will accept the "assignment of benefit" from most insurance companies for the services provided to you. We will do our best to "guestimate" the portion your insurance plan will not pay. Please help us to help you by understanding that it is truly an estimate, as there is no way that we can determine the exact amount the insurance company will pay. We request that you also help us by paying "your portion" on the day of your appointment. This will include any unmet deductibles. After the insurance reimburses our office for your visit, should there be a remaining balance on your account, we will call you. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

Communication

1. 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.

2. 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: _____ Date: _____

Patient's Address: _____

Modified 10-31-13