FUSCO FAMILY DENTISTRY
"Exceptional Dental Care for the Entire Family"
Adam D. Fusco, DMD

Acknowledgement of Receipt
Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices
Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your Protected Health Information.
Our office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature

Date Time

Print Patient's Full Name _____

Witness Signature

Date Time

PATIENT CONSENT

Clinical

1. 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.

2. 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.

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

Patient's Name: _____ Date: _____