Middle Georgia Family Dentistry

Consent for Treatment and Payment Agreement

I hereby authorize Middle Georgia Family Dentistry (Whittle & Gay, LLP) to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations. I understand that my information cannot be sold or used for marketing or fundraising purposes without my signed authorization. I understand that I must be notified of any breaches of information in a timely manner.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to Middle Georgia Family Dentistry of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee. I understand that I am financially responsible for charges not covered. I understand that a billing charge may be added for statements sent. I understand that if there is a balance after 90 days, that collection action may be taken. I realize that if collection action is taken I will be responsible for all collection fees incurred. I acknowledge that patient records may be stored electronically and made available through computer networks. Upon written request, I can receive an electronic copy of available health records or have them sent to a third party.

Healthcare operations include but are not limited to: release of my medical information to my physicians and their offices, labs, or insurance companies participating in my care or treatment and the quality of that care. I acknowledge that I can personally pay for a procedure and request that information about that procedure not be disclosed to my insurance.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is also your responsibility to know the limits of your benefits and to inform the office of any insurance changes. If we are unable to obtain payment from your insurance carrier within a reasonable amount of time the full balance becomes the patient's/guarantor's responsibility. It is understood that if we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we can place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to Middle Georgia Family Dentistry all insurance or third party payments that I receive for services rendered to me immediately upon receipt. **Patient Initial**: ____

I assign the benefits payable for services to Middle Georgia Family Dentistry. **Patient Initial:** ____

Release of Medical Information

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below. (Please print legibly)

_____ _____

_____ _____

*If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from disclosure.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Guardian Signature: _____ Date:_____

Patient's name:_____ DOB:_____