COSMETIC & FAMILY DENTISTRY, P.A.
CONSENT FORM/HIPAA NOTICE

I, _____, hereby grant permission to Dr. J. B. Palles to provide my dental treatment. For the purposes of this Consent Form, treatment is defined as, but not limited to, prophylaxis (cleanings), fillings, extractions, pulpotomies, administering appropriate anesthetics and prescribing appropriate pharmaceutical regimens.

I am aware there are inherent risks attached to any medical and/or dental treatment including, but not limited to, excessive bleeding, allergic reactions to drugs, post operative discomfort, etc.

The staff of Cosmetic & Family Dentistry, P.A. has afforded me the opportunity to read a copy of the Health Insurance Portability and Accountability Act of 1996 Regulations (HIPAA Regulations). A copy of the HIPAA Regulations is provided for my review in the waiting room. If I would like a copy of the HIPAA Regulations, it will be provided upon request.

The HIPAA Regulations describe how medical information about patients may be used and disclosed and how you may have access to this information. The HIPAA regulations applies to all of the paper and electronic records of your care generated by the practice, whether made by the practice or an associated facility. I understand Cosmetic & Family Dentistry, P.A. is taking all reasonable measures to maintain the privacy of my medical records.

In order to better serve our patients and comply with the HIPAA Regulations, we ask that you initial one of the statements below.

_____ Yes, I grant my permission for this office to leave messages pertaining to my dental care, appointments, etc. with family members or on my home answering machine.

or

_____ No, I do not wish this office to leave messages pertaining to my dental care, appointments, etc. with family members or on my home answering machine.

_____ _____

DATE PATIENT/GUARDIAN