YOUR RIGHT TO PRIVACY

M. Max Weaver D.D.S. & Staff are committed to treating and using your protected health information in a responsible manner consistent with both state and federal regulations. Every time you are seen by our office information about your visit is recorded in your dental records. The dental records typically describe symptoms, diagnoses, test results, and treatment plans as it related to your condition. Your dental record is considered to be a legal document that describes the care you received. This information is the means by which you or a third party payter can verify that services were provided. Some or all of your medical information may be used in communications between health professionals or pharmacies, laboratories, etc. who contribute to your care and a coordinated treatment plan. We require all of those organizations to maintain the same level of confidentiality as we do. As such, we may use and disclose your health information only for each of the following purposes:

- **Treatment** means providing, coordinating or managing health care services.
- **Payment** means activities related to obtaining reimbursement or confirming insurance coverage for services.
- **Health Care Operations** involves the business of running our practice in order to provide you with quality service.

Your medical privacy is extremely important to us and, as such, unless you authorize us is writing, your medical information is confidential to everyone.

You have the right to obtain a copy of your dental record and this notice as provided for in **45 CFR164.522, 164.524, and 164.528**.

Patient Name: _____ Relationship: _____

Signature: _____ Date: _____

SIGNATURE ON FILE

I request that payment of authorized insurance benefits be made either to me or my balance to Dr. M. Max. Weaver, D.D.S. (a.k.a. Delta Health Management, Inc.) I authorize any hold of medical information about me to be released in accordance with HIPAA regulations to determine benefits or the benefits payable to related services. I understand my signature authorizes the release of medical information necessary to pay the claim as well as requesting payment be made. If other health insurance is indicated in Item 9 of the ADA 1500 form or elsewhere on the approved claim forms, my signature authorizes releasing of information to the insurer or agency shown. It is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill and any remaining balances after insurance payment is received.

I also understand that I have the right to revoke your authorization to use my health information, except to the extent that action has already been taken.

Patient Name: _____ Relationship: _____

Signature: _____ Date: _____

CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Weaver to conduct, plan & perform necessary treatment and follow-up to provide me with the highest quality care. I understand that the Dentist will thoroughly explain my treatment plan in a comprehensible manner and that my questions regarding treatment will be answered to my satisfaction. I understand that unforeseen conditions or circumstances may arise during the course of my treatment and I authorize the Dentist to perform any care, procedure or treatment he deems reasonable or necessary as a result of these events. I understand that I may refuse to consent to any and all treatments or procedures discussed with me.

Patient Name: _____ Relationship: _____

Signature: _____ Date: _____

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement or receipt of notice, please document the date and time the notice was presented and sign below:

Presented on: (Date) _____ Time: _____

By: (Name & Title) _____