Taunton Dental Associates, P.C.
95 Washington Street
Taunton, MA 02780
508.828.9501

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

-Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
-The Practice reserves the right to change the Notice of Privacy Practices.
-The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
-The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
-The Practice may condition receipt of treatment upon the execution of this Consent.

Patient or Representative Signature: _____ **Date:** _____

Printed Name of Patient/Representative: _____ **Relationship:** _____

Emergency Contact: _____ **Relationship:** _____

Contact's Phone Number: _____

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NO CALL/ NO SHOW POLICY & FEES.

We will make every effort to accommodate your scheduling needs. In return we ask that you help us by keeping your scheduled appointments. If you are unable to do so please notify us at least 24 hours in advance.

CANCELLATIONS ARE REQUESTED 24 HOURS IN ADVANCE, OTHERWISE IT IS CONSIDERED A MISSED APPOINTMENT.

- **First Missed Appointment:** We realize patients get sick, people sometimes forget, or another emergency arises. As soon as you are aware that you can't make the appointment please contact us, even if it is late at night please call and leave a message. Typically we do not charge for the first missed appointment; however, we do reserve the right to do so.

- **Second Missed Appointment:** A missed appointment fee of $50.00 will be charged to your account. This will be charged per family member if multiple appointments scheduled are missed or broken. Please note: Insurance will not pay for this charge. The charge will have to be paid in full before scheduling another appointment.

- **Third Missed Appointment:** You will be charged another $50.00 missed appointment fee. In addition, we also reserve the right to dismiss you from our practice.

Note: Parents bringing in two or more family members at the same time will be restricted from scheduling a double or triple appointment after missing two such appointments for multiple family members.

Name (print): _____

Signature: _____ Date: _____