(Continued)

**FINANCIAL POLICIES:**

1. GUARDIAN: The parent/guardian who brings the child for an appointment is financially responsible for that child on that day of service.
2. NO INSUARANCE: If you do not have dental insurance which we accept, you are expected to pay when services are rendered. If we are not able to verify with Dentaquest's website, we will not file insurance.
3. TENNCARE: If the recommended treatment is not a covered benefit, you will be required to pay when services are rendered. If the service is not a covered benefit, Western Heights Dental will not file a claim with your insurance company for the treatment.
4. CLAIMS AUTHORIZATION: I or my guardian's signature gives permission to release of any information relating to the filing of insurance claims. In addition, the signing is also authorizing payment of the dental benefits directly to the provider of dental services at Western Heights

**I have read, understand and agree to the financial policy at Western Heights Dental:**

Signature:______________________________Relationship to Patient_________________________Date_______________

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## Health Insurance Portability and Accountability Act (HIPAA) CONSENT:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare/dental operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare/dental operations, of the uses and disclosures we may make of your protected heath information, and of other important matters about you protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Richard Myers III, D.D.S., 801 West Oldham Avenue, Knoxville, TN 37921

Right to Revoke: You will have the right to revoke this Consent at any time be giving us written notice of your revocation submitted to the Contact Person listed about. Please understand that revocation of this Consent will not affect action we took in reliance on this Consent before we received your revocation, and we me decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and you Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare/dental operations.

**I have read, understand, and agree to the Consent for Health Insurance Portability and Accountability Act**

Signature:______________________________Relationship to Patient_________________________Date_______________