HIPPA ACKNOWLEDGEMENT

I have received a copy of this office's Notice of Privacy Practices and I have had full opportunity to read and consider the contents of this consent form and your 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 health care operations as set out in the Notice.

*Purpose of Consent

By signing this form, you will consent to use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations as set out in the attached "Notice of Privacy" and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

*Right to Revoke

You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed in our Notice of Privacy Practices. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating if you revoke this consent.

I,_______________________, Date of birth__________________________, have had full opportunity to read and consider the contents of t
(Print Patient Name)
this consent form and your 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 health care operations as set out in notice.

______________________________ Date Signed:____________________

(Patient Signature)

*If signed by parent, guardian, or personal representative on behalf of the patient, complete the following:

______________________________	________________________	__________________
Parent, Guardian, or Representative Name	Relationship to Patient	Date Signed

CONSENT FOR TREATMENT: I hereby consent to treatment to be preformed by Dr. James Kimbrell, DMD Furthermore, I understand the possible complications that might occur from a proposed treatment and that a perfect result cannot be guaranteed. If it becomes necessary to turn this account over for collections, I agree to pay all attorney's fees, court costs, and all other costs of collection of my account. The undersigned agrees to pay for all services rendered. This form was signed in Tuscaloosa County and all services are performed in Tuscaloosa County.

By signing this form, I understand that I am responsible for any balance on this account including any balance not covered or paid by my insurance provider.

Person Responsible For this Account: ***Signature***________________________ Date______________
(Parent or Guardian if Patient is a Minor)

****

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and Consent for Use and Disclosure of Health Information, but we could not obtain because:

____Individual Refused to Sign ____Communication barriers prohibited obtaining the acknowledgement and consent
____An emergency situation prevented us from obtaining acknowledgement and consent
____Other:____
Employees Initials__________

Verify Insurance Coverage
Deductible_______ Family Deductible__________Does it apply to Prev. and Diag.?_______Has deductible been met?_______
Year Dollar Maximum__________Amount Used to Date__________Contract Year_______________

% That Insurance Covers
Preventative(1110)______% How often are cleanings allowed? _______________________
Diagnostic(0330)_______% How often is a panorex allowed?_______________________
Basic(2140)__________%
Endo(3310))__________%
Perio(4341)__________%
Major(2752)__________%
Prosthetic(6242)______%
The following procedures to be entered in the message screen of employer: Waiting Periods________Replacement Waits_______
Fluoride(1203)___________%Limitations___________________ Missing tooth clause______
Sealants(1351)___________%Limitations___________________