SCHNEIDER FAMILY DENTISTRY
HIPAA Privacy Practices Acknowledgement
Consent for Use & Disclosure of Information

Patient Name: _____ Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

The educational pamphlet entitled 'Notice of Privacy Practices' provides information about how Schneider Family Dentistry my use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Notice of Privacy Practices states that reserve the right to change the terms described. Should this happen, we will post the changes in the office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.

By signing below, you acknowledge receipt of our Notice of Privacy Practices.

Signature: _____
(For patients under the age of 18, a parent or guardian must sign)

Consent for Use and Disclosure of Information

I request payment of authorized Medicare/Insurance carrier benefits made on my behalf to Schneider Family Dentistry for any services furnished to me by that provider. I authorize any holder of my medical information to release to the Center for Medicare/Medicaid Services and its agent and/or any other Insurance carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

Signature: _____
(For patients under the age of 18, a parent or guardian must sign)