Schwenksville Dental Care
105 Memorial Drive
Schwenksville, PA 19473

AUTHORIZATION AND RELEASE

I certify that I have read and understand the information on this questionnaire and it is accurate to the best of my knowledge. The questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to notify this office of any changes in my medical status.

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____ Date: _____
Signature of patient *(or parent/guardian if minor)*

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY POLICY

I understand that this acknowledgement is not required to receive treatment at Schwenksville Dental Care. I acknowledge, under federal guidelines of the HIPAA Privacy Notice, that I have been given the opportunity to thoroughly read and have had any questions answered about the Notice of Privacy Practices at Schwenksville Dental Care. I acknowledge receipt of the Notice of Privacy Rights with detailed information regarding how Schwenksville Dental Care may use and disclose my protected health information. I understand that Schwenksville Dental Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

** ***Please check all that apply***

☐ I give my consent for Schwenksville Dental Care staff to leave a message with my health information via:

- ☐ Phone - List Preferred Phone Number: _____
- ☐ Family Member - Household Member Name: _____
- ☐ Email - Email Address: _____

☐ I DO NOT give consent for Schwenksville Dental Care staff to leave a message with my health information

X: _____ ***Date:*** _____
Signature of Patient *(or parent/guardian if minor)*

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please Specify)

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