CLEAR CREEK FAMILY DENTAL
J. Tanner Rust, D.D.S.
609 E. Wells St., Suite F
Ash Grove, Mo. 65604
417-751-9112

I understand that, under the Health Insurance Portability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used but not mandatory for me to sign in order to:

1. Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by this office of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of this office's Privacy Practices prior to signing this consent. I understand that this organization has the right to change its' Privacy Practices from time to time and that I may contact this organization at any time at the above address to obtain a current copy.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that this organization is not required to agree to my requested restrictions, but if this organization does agree, then said organization is bound by such restrictions.

I, hereby understand, that I may revoke this consent in writing at any time except to the extent this organization may have taken action relying on this consent.

Patient Name: _____ **Signature:** _____

Relationship to Patient: _____ **Date:** _____

MEDICAL INFORMATION RELEASE FORM
(HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

❑ Spouse

☐ Child(ren)

❑ Other

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call ❑ my home ❑ my work ❑ my cell Number: _____

If unable to reach me:

❑ you may leave a detailed message

❑ please leave a message asking me to return your call

❑ other _____

The best time to reach me is (day) _____ Time: _____

Signed:_____ Date: _____

Witness:_____ Date: _____

SLEEP APNEA QUESTIONNAIRE

☐ Have you been diagnosed with sleep apnea

☐ Do you currently use a CPAP Machine

Insurance and Payment Disclaimer

Payment for professional services is due at the time dental treatment is provided. Every effort will be made to provide a treatment plan that fits your timetable, budget, and gives you the best possible care.

A 7% discount for payment in full at time of service with cash and a 5% discount for credit or debit card will be provided for our patients with no dental insurance coverage for amounts over $300. We are also excited to be able to provide third party financing through Care Credit, offering interest free financing for 6 or 12 months. *If Care Credit is used, a discount will not be applied.

Insurance is submitted for your convenience. We will submit charges for dental work to your insurance company as long as we have received all of the needed information on the day of your appointment. It is very important that you be familiar with your insurance benefits. We will collect payment from you based on the estimated amount that your insurance is not expected to pay. By law your insurance company is required to pay/respond to each claim within 30 days of receipt. We file all insurance electronically so your insurance company should receive each claim within days of the treatment.

You are responsible for any balance on your account after 90 days, whether insurance has paid or not. We will be glad to send a refund to you once insurance has issued us payment

I, (please print) _____ , have read and understand the above statements regarding the insurance and payment policy for Clear Creek Family Dental.

Signature: _____ **Date:** _____