VALLEY OAK DENTAL GROUP

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENT CAREFULLY.

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

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Out Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other 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.

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:

Contact Person:	Maya Reft		
Telephone:	(209) 823-9341	Fax:	(209) 823-7836
E-mail:	valleyoakdentalgroup@gmail.com		
Address:	1507 W. Yosemite Ave, Manteca CA 95337		

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 above. 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 you if you revoke this Consent.

SIGNATURE

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.

Signature:_____ Date _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

1507 West Yosemite Avenue • Manteca, CA 95337

(209) 823-9341•valleyoakdentalgroup.com

Allowable Fees

In an ongoing effort to serve you, we would like to help you understand your insurance benefits and patient statements.

We strive to give the most accurate financial estimates based on the information that your insurance carrier gives to us. No one likes surprises, and we try very hard to ensure that you understand the cost of your dental treatment prior to receiving care.

It is important that you understand that until we actually receive payment from your insurance company, we can only provide an estimate of your share of costs.

We are increasingly aware of insurance companies who base their payments on what they call an “allowable fee” rather than our usual and customary fee. Generally, the allowable fee is an internal, unpredictable amount that is less than our fee. This effectively lowers your insurance benefit. 100% coverage can sometimes be less than payment in full when the “allowable fee” is less than our usual and customary fee.

Explanation of Benefits

Please be sure to review your “Explanation of Benefits” that should be sent to you by your insurance company within 3-4 weeks after your appointment. This will show you the amount we have billed, your insurance company’s “allowable fees”, the amount they paid and your expected patient responsibility. As always, if there is something you do not understand, we encourage you to call right away and we will be happy to assist you in understanding your billing statements or your insurance correspondence.

Assignment of Benefits

I assign all dental payments to which I am entitled from any Insurance Company to Valley Oak Dental Group. I wish this to stay in effect until revoked by me in writing. I understand that I am financially responsible for all charges if they are not paid by my Insurance Company within 30 days from claim and billing date (professional services are rendered and charged to the patient or guardian and not to the Insurance Company).

Collection Fees

In the event that legal action is necessary to collect a debt, ALL fees associated with collection, including but not limited to, attorney fees will be assessed and are the responsibility of the patient and/or account holder.

I authorize Valley Oak Dental Group to release any dental information to my Insurance Company. I wish this to stay in effect until revoked by me in writing.

I have read this agreement and understand it. I have also received a copy of this agreement.

_____

Patient or Patient’s Guardian Date