



AUTHORIZATION AND RELEASE

- I acknowledge that I have completed the patient information form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any member of the staff responsible for any errors or omissions that I may have made. If there are any future changes to this history record, I will inform the practice
- I consent to examination by the orthodontist and authorize him/her to perform diagnostic procedures and treatment as may be necessary to proper orthodontic care.
- I authorize release of any information pertaining to my child's health care, advice, and treatment provided to third party payers or to other health care practitioners.
- I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I agree to be fully responsible for the total payment for procedures performed in this office, as well as for any necessary collection and attorney fees.
- I authorize release of any information relating to this claim to my insurance company.
- I authorize payment of any insurance benefits, otherwise payable to me, directly to PDOC.
- I give permission for the use of photographs and records made in the process of examination and treatment to be used for the purpose of research, education, or publication in professional journals.
- I give permission for the use of photographs and videos to be used for the purpose of our website Facebook, YouTube, Twitter and other social media networks.
- You have the right to revoke this authorization at any time in writing. However, your revocation will not be effective to the extent that this authorization has been relied on.

Signature(Parent if under 18): _____ Patient Name: _____ Date: _____

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

- Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used with your treatment, payment of your account or health care operations. (i.e., performance reviews, certification, accreditation and licenses).
- You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with the consent.
- You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.
- We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes and the changes may not be in reliance on this Consent.

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

Signature(Parent if under 18): _____ Patient Name: _____ Date: _____