MACEDONIA DENTAL HEALTH GROUP

D. Todd Russell, DDS

Privacy Practice

I understand that I have certain rights to privacy regarding my protected health information. These rights are given o me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to disclose my protected health information to carry out:

- Treatment. Including direct or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practice practices which contains a more complete description of the uses and disclosure of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to the requested restrictions. However, if you do agree, you are not bound to comply with the restriction(s). I understand that I may revoke this consent in writing at any time. However, any use or disclosure that may occur prior to the date I revoke this consent is not affected.

Cancellation Policy

We require at least 24 hours notice for cancellation of an appointment. If we are not notified within the 24 hours before your appointment is scheduled it is considered a broken appointment. You will be charged a broken appointment fee of up to $100.00. After 2 broken appointments you will be dismissed from the practice.

Print Patient Name: _____

Relationship to Patient:_____

PARENT / GUARDIAN / SELF

Date Signed:_____

Patient Signature:_____

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