**Consent**

I hereby authorize Dr. Rosander and/or his staff to take x-rays, models, photographs and other diagnostic aids deemed necessary by Dr. Rosander to make a thorough diagnosis of my/my child’s dental needs. Upon such diagnosis, I authorize Dr. Rosander to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide that care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks and that I can ask for a complete recital of any possible complications. I understand, acknowledge, and agree that photographs and images of me may be shown to other patients, potential patients and/or doctors for treatment and educational purposes. I further understand that my name or identifying information will be kept confidential.

**Financial Agreement**

As a courtesy, this office will help prepare and submit your insurance claims.By signing this form, I authorize this office to submit insurance claims and to contact my insurance company on my behalf. **I understand that my dental benefits are a third party contract between my employer and the insurance company and that any fees not covered by insurance are my financial responsibility. I agree to pay for all necessary services regardless of insurance coverage.** I agree to pay all deductibles and co-pays at the time of service. I understand that any estimates given are not a guarantee of benefit.I understand that payment plans are available to assist with payment and that all financial arrangements must be made in advance. This practice depends on payment from the patients for the costs incurred in their care. Should my account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney’s fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

**I understand that in order to ensure that other patient’s appointment times are honored and that I receive the best possible care, I may be asked to reschedule if I arrive more than 10 minutes late. I agree to keep all scheduled appointments unless I notify the office at least 24 hours prior. Failure to keep a scheduled appointment may result in a missed/cancelled appointment fee of $35 per hour scheduled.**

**HIPPA Information**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out treatment (including direct or indirect treatment by other healthcare providers), obtain payment from third party payers (ie. insurance companies), and the day-to-day operations of this practice. I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures 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 heath care options, but that you not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected. I grant my permission for you to contact me to discuss matters related to this form.

**I have read the above conditions of treatment and payment and agree to their content.**

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Print Name

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Signature of patient, parent or guardian

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Relationship to patient