Established 1918

California Oral Surgery Center - Stockton Oral Surgery

Oral and Maxillofacial Surgery
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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent
Name/please PRINT: _____

Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:
Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, or the uses and disclosures we may make of your protected health information, and of other important 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 the protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including and revisions, at any time by contacting the office.
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 of this Consent before we received your revocation, and that we may decline to treat you or 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 form, I am giving my consent to your use of my disclosure of my protected health information to carry our 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 Name: _____
Relationship to Patient: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
*** You may refuse to sign this acknowledgement ***

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgments could not be obtained because (circle one):
1. Individual refused to sign
2. Communications barriers prohibited obtaining the acknowledgment
3. An emergency situation prevented us from obtaining the acknowledgment
4. Other (please specify)_____

PAYMENT POLICY

Insurance Patients: Due to the overwhelming number of insurance companies and their different policies, it is impossible for us to give you a true estimate of the proposed insurance reimbursement. In order to bill your insurance company, we must have have your insurance information, including the mailing address and your ID number. Your insurance policy is a contract between you and your insurance company. You are responsible for knowing the benefits of your individual plan. We require a minimum payment of 50%, unless you are a Delta Dental member, to be made at the time services are rendered. If this is not acceptable, we are willing to pre-authorize the proposed treatment in writing, which usually delays surgery for 6-8 weeks. It is your responsibility to pay for services not covered by your insurance company.
Non-Insurance Patients: Payment in full is expected at the time of service unless other financial arrangements have been made.

PATIENT OR RESPONSIBLE PARTY SIGNATURE_____**. Date**_____