Today's Family Dental

Quality Dentistry for Today's Families

715 North 64th, Waco, Texas 76710

Tel: 772-3922 X Fax: 776-6230

www.todaysfamilydentalwaco.com

J. Gary Williams, D.D.S. Curtis A. Quigley, D.D.S.

FINANCIAL RESPONSIBILITY

I hereby authorize and request the performance of dental services for myself or my dependent. I also authorize the dentist to perform any advisable dental diagnostic procedures, and provide any medications and treatment as may be necessary to make a thorough diagnosis of my (or my dependent's) dental needs.

If applicable, I authorize all payment of insurance benefits directly to the dentist, otherwise payable to me.

I also understand and acknowledge I am financially responsible for all fees for services provided by Today's Family Dental for myself or my dependent, for payment in full on all accounts, regardless of insurance coverage and payment.

Please complete the following information. (Responsible Party cannot be a minor.)

Patient Name:_____

Responsible Party:_____
(Person financially responsible for this account)

Relationship to Patient:_____ **Driver's Lic#:**_____

Address:_____**Home Phone:**_____

City, State, Zip:_____**Work Phone:**_____

_____ _____

Signature ***Date***

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PATIENT CONSENT - HIPAA

(Right to Privacy of Protected Health 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 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 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 health care operations, but that you are 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.

Signed this _____day of _____, 20_____.

Signature: _____

Print Patient Name: _____

Relationship to Patient: _____