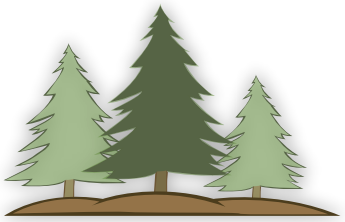

Dr. Roger C. Stoddard DDS, PA
Family Dentistry

CONSENT TO TREAT FORM

1524 White Bear Avenue North
St. Paul, MN 55106-1606
Office | (651) 776-1597
Fax | (651) 776-4045
theteam@stoddarddental.com
www.stoddarddental.com

PATIENT INFORMATION FOR PATIENT GIVING CONSENT

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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 preform treatment, payment activities, and healthcare 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 f the uses of disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to ask for a copy and read it carefully before signing this consent. It is available upon request.

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 you protected health information we maintain.
You may obtain a copy of our Notice of Privacy Practices by contacting Dr. Stoddard at any time.

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation to Dr. Stoddard. Please understand the revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

PLEASE SIGN BELOW TO GIVE CONSENT TO BE TREATED

I, _____ have had full opportunity to read and consider the contents of this consent for and Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out 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: _____ Relationship: _____

CONSENT TO TREAT FORM CONTINUED BELOW

PLEASE INITIAL EACH OF THE FOLLOWING:

_____ I hereby authorize the dental office to perform such diagnostic procedures as x-rays, intraoral images, impressions and oral exams. To administer medications and therapeutic procedures as may be necessary for proper dental treatment.

_____ I am financially responsible for this account. I hereby authorize payment to the dental office of insurance benefits otherwise payable to me. I understand that the insurance carrier may pay less than the actual fee for service and that I am responsible for the balance after insurance payments and discounts have been applied. I am also responsible for all non-covered services.

_____ I understand that it is by responsibility to be aware of my insurance benefits and provide the dental staff with accurate and up to date insurance information in order to process my claim. I understand that not providing the information could result in non-payment by my insurance carrier, and that I am financially responsible for all services rendered against my account or the accounts of my dependent children.

_____ I hereby authorize the dental office to notify me of future appointments by use of a postcard, telephone message, e-mail or text message.

_____ I understand that a finance charge of 1.5% per month will be added to unpaid balances of 90 days of more.

BY SIGNING BELOW, I AGREE TO HAVE READ THE ABOVE STATEMENTS AND HAVE INDICATED BY INITIALING EACH THAT I UNDERSTAND MY RESPONSIBILITIES.

By signing below, I agree to have read the above statements and have indicated by initialing each that I understand my responsibilities.

Signature:_____ Date:_____

(Parent signature required if child under 18 years of age.)

I grant permission to Dr. Stoddard and his associates to discuss my appointments, treatment and financial responsibilities with:

_____