Jason D. McCargar D.M.D., Ltd.

9751 North 90th Place Scottsdale, Arizona 85258
480-860-8282

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient giving Consent

Name____

Address____

Telephone______________________ **E-mail**______________________
Social Security____________________ **Patient #**____________________

Section B: 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 healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice Of Privacy Practices before you decide to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of 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 is available at the front desk, 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 copy which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any versions of our Notice by contacting:

Contact Person: Any office administrator Telephone: 480-860-8282
Office: 9751 North 90th place, Scottsdale, Arizona 85258

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 the revocation of this consent will not affect any action we took in reliance of your Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

Name: I,______________________, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices, I am giving my consent to your use and disclosure of my protected health information to carry out our treatment payment activities and health care operations.

Signature 2.____________________Date_________________
If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal representatives name: ______________________Relationship ____________

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For patients with Insurance:

Benefits for dental treatment vary from plan to plan. Additionally, "Out of Network" benefits are subject to deductibles that vary with each plan. In an effort to provide clear communication with our patients, please be advised as follows:

- We are a contracted provider of Delta Dental "Premier". Any other PPO or Indemnity insurance will be considered "out of network".
- The contractual agreement for your dental benefits is between you and the insurance company. **We provide billing as a courtesy.**
- For all insurance carriers that we have a contractual agreement with, we will accept the "In Network" benefits outlined on your individual Explanation of Benefits. You will still be responsible for any and all co-pays, deductibles or co-insurance amounts due in accordance with explanation of benefits.
- For all patients with a non-contracted insurance company, you will be responsible for all charges not covered by your plan.
- When insurance benefits have been exhausted and/or terminated, you will be responsible for the charges incurred.
- Our staff will call to verify dental coverage and according to your insurance this is **NOT** a guarantee of payment, just verification of benefits. We cannot be held responsible for percentages or benefits estimated with this information.
- In all cases, you will be responsible for any non-covered service, deductible, co-pays and co-insurance amounts deemed as patient responsibility by your insurance company.
- **However, it is your responsibility to know your dental plan coverage.**

For patients with and without insurance:

- Payment is due when services are rendered. Accounts may be assessed a late charge of 1 ½ % per month, not to exceed 18% interest. If an account is sent to collections a collections fee will be added to your account.
- Should your account be placed in collection, you will be responsible for any and all fees and court costs incurred.

I have read and agree to be financially responsible for all services performed by Dr. Jason McCargar and staff.

_____ _____

Patient Date

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Parent or Guardian for children under 18