Responsibility and Consent Statement

Person Responsibile for account: _____

Relationship to patient: _____

Address: _____

Mobile Phone: _____

Birth Date: _____

SSN: _____

Employer: _____

Occupation: _____

Consent

I hereby authorize and request the performance of dental services for myself or (patient's name)_____ . I also authorize the dentist Dr. Louis Pahopos, 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 dependant's) dental needs.

I authorize the release of any information concerning my (or my dependant's) healthcare, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I am authorizing any information concerning my (or my dependant's) healthcare, advice, and treatment to another dentist.

I authorize payment of insurance benefits directly to the dentist, otherwise payable to me.
I understand and acknowledge I am financially responsible for the services provided for myself (or my dependant) for payment in full on all accounts, regardless of insurance coverage.

_____ _____

Patient or Responsible Party Signature | Date

Elmhurst Family Dental
Dr. Louis A. Pahopos, D.M.D.
314 N York Street
Elmhurst, IL. 60126

Statement of Privacy Practices

Our office is dedicated to protect the privacy rights of our patients and the confidential information that you have entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that may affect your rights.

Protecting Your Personal Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Illinois. This includes issues relating to your treatment, payment and dental care protocol. Your personal health information will never be otherwise given to anyone, even family members, without your written consent. Of course, you may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to former, current and future employees, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations and comply with the law. This may include your name, address, telephone number(s). Social Security Number, employment information, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental personnel under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voice messages, answering machines and postcards.

Patient Rights

You have a right to request copies of your healthcare information, to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge you for your copies in the amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the US Department of Health and Human Services.

Patient or Responsible Party Signature

Date

Elmhurst Family Dental
Dr. Louis A. Pahopos, D.M.D.
314 N York Street
Elmhurst, IL. 60126

24-HOUR CANCELLATION POLICY

Our practice values being able to provide each patient the best care at an efficient and timely manner. In order for us to provide you and other patients with the best care and keep costs down, we ask for a notice of 24 hours in advance for any changes of your appointment. When an appointment is broken without 24 hours notice it is unfair to the patients waiting to get in for needed dental care, and to our staff.

When a cancellation has been made without a 24 hour notice it is necessary to charge the patient an office fee of $50. Please sign and date below to show that you are aware and understand our cancellation policy.

Thank you in advanced for your compliance.

(I have read and understand the cancellation policy).

Patient or Responsible Party Signature

Date

Elmhurst Family Dental
Dr. Louis A. Pahopos, D.M.D.
314 N York Street
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