Sarver Family Dental

Jerome Sarver, D.D.S.

6035 Sterling Creek Road • Portage IN 46368 • 219-850-1218

HIPAA RECEIPT / CONSENT FORM

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number: _____ DOB: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing the form, you will consent to our use, and disclosure, of your protected health information to carry out treatment, payment activities, and healthcare operations. You may refuse to sign this acknowledgment & authorization. In refusing we **may not be allowed** to process your insurance claims.

Notice of Privacy Practices: You have the right to read the 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, 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 accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

You may obtain a copy of our Notice of privacy Practices, including an revisions of our Notice, at any time by contacting:

Compliance officer:	**Practice Administrator -- Jerry Sarver, DDS**
Telephone:	**219-850-1218**
E-mail:	**info@sarverfamilydental.com**
Address:	**6035 Sterling Creek Rd, Portage, IN 46368**

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 on this Consent before we received your revocation.

SECTION C: SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and the 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. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS TO BE SENT TO OTHER ATTENDING DOCTORS / FACILITIES IN THE FUTURE.

Signature: _____ **Date:** _____/_____/_____

If this consent is signed by a personal representative on behalf of the patient, complete the following

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION D: FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communication barriers prohibited obtaining the acknowledgment**
- ☐ **An emergency situation prevented us from obtaining acknowledgment**
- ☐ **Other (please specify)** _____

Signature: _____ **Date:** _____/_____/_____

You are entitled to a copy of this consent after you sign it.

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HIPAA DISCLOSURE / RESTRICTIONS

SECTION E: AUTHORIZED CONTACT METHODS

I authorize contact from this office to *confirm my appointments, treatment, and billing information via:*

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ E-mail Confirmation
- ☐ **Any of These**

I authorize *information about my health* to be conveyed via:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ E-mail Confirmation
- ☐ **Any of These**

SECTION F: PATIENT/RELATIVE CONSENT

I, _____, understand that by signing this Consent form, I am giving my consent to Sarver Family Dental to disclose and discuss my protected health information to carry out treatment, payment activities, and health care operations with the following people.

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Compliance officer listed on Section B.

Signature of Patient or Legal Guardian: _____ Date: _____/_____/_____

SECTION G: RESTRICTION OF CONSENT

I request that Sarver Family Dental restrict the disclosure of my Protected Health Information to those specified below:

NAME: _____ NAME: _____

NAME: _____ NAME: _____

Signature of Patient or Legal Guardian: _____ Date: _____/_____/_____

If this Restriction of Protected Health Information is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____