Ukiah
FAMILY DENTISTRY
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Office Procedures

1. I authorize the following person(s) to be my personal representative, which means the doctor and staff may speak freely to the named personal representative regarding all my protected health, medical, dental, treatment and billing information.

   Name **Relationship**

   _____ _____

2. **For my child(ren)**, I authorize the following named person(s) to authorize medical treatment for my named children. The Doctor and staff may speak freely regarding my child(ren) protected health, medical, dental, treatment and billing information.

   Name of Authorized Person/Relationship **List of Minor Children**

   _____ _____
   _____ _____

3. I authorize Ukiah Family Dentistry to examine and provide dental treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to Ukiah Family Dentistry. I authorize Ukiah Family Dentistry to release any dental/medical or incidental information that may be necessary for either medical/dental care or in the processing of applications for financial benefit. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray departments, specialists and providers which are assigned to me according to my insurance policy rule. It is Ukiah Family Dentistry's procedure to share Protected Health Information with labs and consulting physicians, dentists, insurance companies, trust funds and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

4. _____ **I understand that payment is due at the time of service, unless other arrangements have been made.**
   initial

5. I authorize Ukiah Family Dentistry or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis. Upon such diagnosis, I authorize the Doctor to perform all recommended treatment, which is mutually agreed upon by me. I agree to the use of anesthetics, sedatives and other medications necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
6. Our office is HIPAA-compliant and the staff has been trained in the HIPAA Privacy Act. We will do everything we can to protect your Patient Health Information. However, our office was designed before the HIPAA Law so please be respectful of other patients' privacy.
7. I have received the Dental Materials Fact Sheet dated May 2004.

8. It is our office procedure that we mail reminder postcards asking you to call to schedule an appointment and we also leave messages or text reminding you of your appointment(s).

9. _____ The Limited Warranty is available upon request. Failure to have your recommended
   initial clinical hygiene appointments and exams voids the limited warranty.

10. _____ A broken appointment is a loss to everyone. Please give **48 business hours'** notice if you are unable to
    initial keep your appointment. You may be charged for a missed appointment.

Signature of Patient/Guardian: _____ **Date:** _____