◆ Permissions, Consents, and Responsibilities ◆

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Authorization to Discuss My Account

I authorize the staff of Michael D. Fedyna, D.D.S. & Associates to: *(check all that apply)*

_____ Leave messages on my answering machine/voice mail.
_____ Leave messages with someone in my household.
_____ I give my permission for the doctor & staff to speak with my family and/or other designated persons regarding appointments, test results, and/or financial information. (*Please list name(s) below.)*

Name: _____
Relationship to the patient: _____
Phone: _____

Name: _____
Relationship to the patient: _____
Phone: _____

X_____ X_____
(signature of patient or authorized representative) (print name) (date)

_____
(if signed above by representative, state relationship to patient)

Patient Financial Responsibility

I understand that Michael D. Fedyna, D.D.S. & Associates will, as a courtesy to me, submit the charges for my visit to my primary and/or secondary insurance carriers. If there is any question regarding coverage, benefits, or payment for the services provided, I understand that it is my responsibility to resolve this. I also understand that I am financially responsible for any covered or non-covered services which are not paid by my primary and/or secondary insurance and that any unpaid charges over 60 days old will become my responsibility, with payment due from me. If my balance over 60 days is not paid, the information necessary for collection purposes will be forwarded to a professional collection agency.

X_____ X_____
(signature of patient or authorized representative) (print name) (date)

_____
(if signed above by representative, state relationship to patient)