JOSEPH M. CROW, D.M.D., P.C.
4634 BIT & SPUR ROAD
MOBILE, AL 36608
(251)342-4926

GENERAL CONSENT FOR TREATMENT

1. I hereby authorize Dr. Crow & Staff to take any x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis of dental health needs.
2. Upon such diagnosis, I authorize Dr. Crow & Staff to perform all recommended treatment mutually agreed upon by me; and to employ such assistance as required, to provide proper care.
3. I agree to be responsible for payment of all services rendered on my behalf, or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 20% charge may be added to my account.
4. I understand that all appointments must be cancelled within 24 hours of the appointment time, or a missed appointment fee of $25.00 may be assessed.

NON-COVERED SERVICE POLICY

We want to provide you with the best dental services available for your care. However, some services may not be covered under the terms of your dental insurance contract. The cost of these services will be the Patient's (or Account Guarantor's) financial responsibility. Rest assured, our office will only perform treatment that is necessary and appropriate for your care. Our staff does their best to estimate what your insurance contract will pay for services rendered. However, this is only our best estimate and any unpaid balance will be the responsibility of the Patient (or Account Guarantor). If you have any requestions regarding which services are not covered, a member of our office staff would be happy to answer them.

NOTICE OF PRIVACY PRACTICES & HIPAA COMPLIANCE

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you, Joseph M. Crow, D.M.D., P.C., to use and disclose my protected health information to carry out Treatment; Obtaining payment from third party payer (Insurance company); & The day-to-day operations of Joe Crow Dentistry. I have also been informed of and given the right to review and secure a copy of Joe Crow Dentistry's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain a current copy of this notice. I have the right to request restrictions on how my protected health information is used and disclosed to carry out the aforementioned and that you are bound to comply with this restriction. I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

*****By signing this document, I am acknowledging that I have read and agree to all the terms stated above.***

Print Patient's Name Date

Signature of Patient/ Responsible Party (Account Guarantor)