HIPAA - Patient Consent Form & Financial Policy for Dental Services

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations at our dental clinic.
The patient understands that:

- **Protected health information may be disclosed or used for treatment, payment, or health care operations.**
- **Galleria West Family Dental has a Notice of Privacy Practices, and the patient has the opportunity to review this Notice.**
- **Galleria West Family Dental reserves the right to change the Notice of Privacy Practices.**
- **The patient has the right to restrict the use of their information, but the Practice does not have to agree to the restrictions.**
- **The patient may revoke this Consent in writing at any time and all future disclosures will then cease.**
- **Galleria West Family Dental may condition receipt of treatment upon the execution of this Consent.**

I will be informed of the treatment plan and associated fees; and I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist and/or GWD has a contractual agreement by my plan prohibiting all or a portion of such charges. I consent to and authorize the dentist of Galleria West Family Dental to perform treatment discussed regarding my dental care. I understand that treatment can change mid-course and alter the original treatment or cost, and I am aware that any questions will be addressed. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the dental entity of Galleria West Dental, SC.

At any point in time, you are referred to a Specialty Office and it is your responsibility to verify they are part of your accepted In-Network Plan. We are unable to obtain that information for you, as the policy is owned by you.

I agree to pay in full upon receipt of my statement from Galleria West Dental. Regardless of any court orders, children brought in for treatment by a guardian, said individual will accept responsibility for payment due. To the extent permitted by law, I consent to your use and disclosure of my (PHI) Protected Health Information to carry out payment activities in connection with this claim.

Non-Insured or individuals utilizing a discount plan, are responsible for paying at time of service. All Major Credit Cards are accepted along with a check. No cash is accepted.

To qualify for monthly payment, you must apply for Care Credit, prior to visiting. When you qualify for Care Credit, we utilize either a 6 month or 12 month plan, collected at time of service

Galleria West Family Dental

18900 W Bluemound Rd. Ste 218 Brookfield, WI 53045 262-754-2727

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By signing this form, you agree to and consent to the attached information.

Name of Patient and/or Representative:
_____ (print)

Relationship to Patient (if other than patient):
_____ (print)

Additional Family Members not mentioned above:
_____(print)

Signature: _____ **Date:** _____