Dr. William D. Compton Jr. D.D.S.

Your Privacy Is Important to Us.

Acknowledgement of Receipt of Notice of Privacy Policies

(**Adult**)

I have received a copy of the Notice of Privacy Practices of **William D. Compton Jr D.D.S.** I hereby authorize, as indicated by my signature below, **William D. Compton Jr. D.D.S**, to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name **Address**

_____ _____

Signature **Date**

Please indicate your preferred means of communication with an 'X':

__ - Please call my mobile phone number (____) _____ - _____
__ - Please call my home phone number (____) _____ - _____
__ - Please call my home phone number (_____) _____ - _____
__ - Please text my mobile phone number
__ - Please contact me via email _____

Please list authorized persons whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians.

Name	**Phone Number**	
_____	_____	Date Added/Removed _____
_____	_____	Date Added/Removed _____

********** *– For office use only –* **********

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Policies, but acknowledgement could be obtained due to the following:

__ - Individual refused to sign
__ - Communication barriers prohibited obtaining the acknowledgement
__ - An emergency prevented us from obtaining the acknowledgement
__ - Other (please specify) _____

Staff Person Initials _____

Clinical

1. I authorize William D. Compton Jr., D.D.S. to perform all recommended treatment.
2. I authorize **The Practice** (William D. Compton Jr. D.D.S.) to take radiographs, study models, photos, and other diagnostic aids or materials (Collectively, *Diagnostic Material*) as needed to make a thorough diagnosis. I authorize that such Diagnostic Materials may be released to third-party payors and/or other health care professionals.
3. I authorize the use of anesthetic, sedatives and other medication, as needed, and am fully aware that using anesthetic involved certain risks, including but not limited to redness and swelling of tissue, pain, itching, vomiting, dizziness, cardiac arrest, drowsiness and/or lack of coordination.

Financial

4. I am responsible for the payment for all services rendered on my behalf. I understand that payment is due when services are rendered OR when an arrangement has been established and agreed upon between **The Practice** and patient. I am aware that if no such arrangement exists, the practice has the authority to tabulate a 1.5% MPR or 18% APR to my account for balances that are 30-days overdue. Should my account become delinquent, I will be responsible for all additional costs, including reasonable attorney fees.
5. A **$50.00** missed appointment fee may be charged to my account for all missed appointments or cancellations less than 24-hours by me (the patient). I am aware that to hold down operating costs, 24-hours' notice of cancellation is required.

Insurance

6. I authorize **The Practice** to release staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records and other Diagnostic Material about my medical history, services rendered or recommended treatment.
7. I authorize **The Practice** to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to **The Practice** the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided

I have read this Patient Consent and agree to all terms and conditions herein.

Patient Name: _____ Date: _____

Patient Signature:_____

Updated 10/2024