FIRST STATE DENTAL, P.A.

Thank you for choosing First State Dental, P.A. as your dental provider. We are committed to the latest in technical advances delivered with comfort and care. Below is some important information which we would like to share. All patients must complete and sign this form, prior to receiving services.

Patient Name (PLEASE PRINT): _____

How do you want to be addressed when summoned from the reception area (CHOOSE ONE): ○ First Name Only ○ Proper Surname ○ Other: _____

CANCELLED / MISSED APPOINTMENT POLICY:
When you schedule a dental appointment, First State Dental, P.A. reserves time in the schedule that is no longer available to other patients. As the time is reserved especially for you, if you are unable to keep your commitment your advanced notice will allow another patient access to dental care. First State Dental, P.A. reserves the right to charge a $35 broken appointment fee for appointments that are missed and/or cancelled with less than two (2) business days' notice. In the event that multiple appointments are missed and/or cancelled with less than two (2) business days' notice, the patient may be placed on a list to be called when an opening allowing the necessary time needed for the patient's dental care, arises in the schedule. At all times, First State Dental, P.A. reserves the right to dismiss the patient(s).

HIPAA Consent:

With my consent, First State Dental, P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operation (TPO). I also authorize First State Dental, P.A. to call my home, cell, or designated location, send email and/or text messages, and leave a message on voicemail, or in person, in reference to any items that assist First State Dental, P.A. in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results, among others. With this consent, First State Dental, P.A. may mail to my home, cell, or other designated location any items that assist the practice in carrying out TPO, such as patient statements.

Please list the persons with whom we may discuss your information, if needed.

Name: _____Phone #: _____Relationship to the patient: _____

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I give First State Dental, P.A. permission to send appointment reminders and notifications through:

○ Text Messages: _____ ○ Email: _____
CELLPHONE NUMBER E-MAIL ADDRESS

By signing this form, I am consenting for First State Dental, P.A. to the use and disclosure of my PHI to carry out TPO. I have the right to refuse to sign or revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. This consent will remain in effect until I request in writing to cancel my authorization. I understand the above guidelines, have had the opportunity to read the HIPAA Notice of Privacy Practices, and to ask questions, and upon my request will be given a copy of the privacy notice.

Remain in effect (CHOOSE ONE): ○ Until _____ _____ ***OR*** ○ Indefinitely _____
CHOOSE DATE INITIALS REQUIRED INITIALS REQUIRED

I HAVE READ ALL OF THE POLICIES ABOVE AND AGREE TO ABIDE BY THE TERMS AND CONDITIONS AS STATED IN EACH.

_____ _____
Signature of Patient (Parent/Guardian if Minor) / Responsible Party Date

_____ _____
Signature of First State Dental, P.A. Employee Date