Frankfort Smiles Dental

301 N. White Street, Suite BB Frankfort, IL 60423

Patient HIPAA Authorization Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or dis/closed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this disclosure, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Acknowledgement. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPAA).

The patient understands that:

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

I acknowledge receipt and understanding of this document.

Sign: _____ Date: _____

Practice Cancellation Policy

Our office requests a 24-hour cancellation notice. **Failure to call, or no-shows, will be charged a $50 administrative fee** that is not billable to insurance. This fee must be paid by your next visit. Furthermore, if multiple cancellations occur- the office has the right to request a $75 non-refundable deposit to make another appointment. Deposit will be applied to co-payment at next visit upon arrival to appointment.

I acknowledge and understand the cancellation policy of the office.

Sign: _____ Date: _____