



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

The following is an itemized description of the questions appearing on the new form. Thoroughly complete the Billing Dentist Section to facilitate prompt and accurate reimbursement and to reduce follow-up inquiries.

1. Dentist's pretreatment estimate or statement of actual services and identification of specialty: Complete appropriate box to expedite processing and decrease chance of error. Indicate dentist's specialty by using the following abbreviations: END (Endodontist); OPY (Oral Pathologist); ORT (Orthodontist); OSY (Oral Surgeon); PDT (Periodontist); PED (Pedodontist); PHD (Public Health Dentist) and PST (Prosthodontist).
 2. Medicaid Claim, EPSDT, prior authorization number: Check for government-funded benefit programs.
 - 3-7. Carrier name, address, city, state, zip code: Carrier information where the claim is to be sent.
 - 8-11, 16. Patient name, address, city, state, and zip code: Include the patient's legal name.
 12. Patient date of birth: Necessary to determine eligibility.
 13. Patient ID number: Used by dental office to identify patient. Not required to process claim.
 14. Sex: Necessary for identification purposes and for statistical analysis.
 15. Patient phone number: Necessary if questions arise that require immediate attention.
 17. Relationship to subscriber/employee: Relationship between the insured person and the patient may affect the patient's eligibility, as well as level of benefits available.
 18. Employer/School name and address: Eligibility of the dependent patient may be affected if the patient is over a certain age and is still a full-time student. This information may be necessary for coordination of benefits (COB).
 19. Subscriber/Employee ID # or Social Security number: This information refers to the insured person and is not necessarily the patient. The Social Security number (SSN) is commonly used for computer and manual processing of claims.
 20. Employer name: Self explanatory.
 21. Group number: Refers to the master contract policy number assigned to the employer group.
 - 22-30. Subscriber/Employee information: Refers to the insured person; and is not necessarily the patient.
 31. Is patient covered by another dental plan: Necessary to determine multiple coverage and COB.
 32. Policy #: Refers to master contract policy number assigned to the employer group.
 - 33-35. Other subscriber's information: Refers to employee with policy number in box #32.
 36. Plan/Program name: Necessary to identify national programs such as TRICARE.
 37. Employer/School: Refers to person in box #33. Necessary for eligibility requirements and COB.
 38. Subscriber/Employee status: Refers to person in box #22. May be necessary for eligibility and COB.
 39. Patient signature block: The patient is defined as an individual who has established a professional relationship with a dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.
 40. Employer/School: Refers to person in box #22. May be necessary for COB. Not required by all carriers.
 41. Employee/subscriber block: Necessary when the patient and/or the dentist wish to have benefits paid directly to the provider. This is an authorization of payment and does not constitute an assignment of benefits. It does not create a contractual relationship between the dentist and the payer.
 - 42-43, 46, 50-52. Information for Billing Dentist, or Dental Entity: The individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payments or correspondence that will be remitted to the billing dentist.
 44. Provider ID #: Necessary when carriers assign unique numbers to providers that differ from the Social Security number or the tax payer identification number (T.I.N.).
 45. Dentist's Social Security number or T.I.N.: Refers to dentist or dental entity in box #42. The Internal Revenue Service requires that either the Social Security or T.I.N. of the billing dentist or dental entity be supplied only if the provider accepts payment directly from a third-party payer. Report the SS# if the billing dentist is unincorporated. Report the corporation T.I.N. if the billing dentist is incorporated or the entity T.I.N. when the billing entity is a group practice or clinic.
 47. Dentist's license number: Refers to the license number of the billing dentist. This may differ from that of the treating dentist which appears in the Dentist's signature block (62).
 48. First visit date current series: Necessary to determine what services are covered when a patient becomes eligible in the middle of an active treatment plan.
 49. Place of treatment: Necessary to determine if medical and/or hospital coverage including dental benefits may be activated. ECF stands for "extended care facility."
 53. Radiographs or models enclosed: Complete when diagnostic materials are submitted.
 54. Is treatment for orthodontics? Necessary to determine the prorated benefit.
 55. If prosthesis is for a crown, bridge or denture, is this initial placement? Determines eligibility and liability.
 56. Is treatment result of occupational illness or injury? Refers to possible application of Worker's Compensation, which would alter coverage available and carrier involved.
 57. Is treatment result of auto accident? Necessary to determine reimbursement in no-fault automobile accident cases. Indicates whether another party's insurance may be responsible. Important for COB.
 58. Diagnosis Code Index: When reporting the diagnosis(es) for treatment, refer to the ADA's SNODENT diagnostic codes (available in the year 2000). Record the 5-digit diagnosis code(s) in spaces 1-8, as necessary. The submitter should record the 5-digit diagnosis code(s) on line 1 through 8. In box 59, the number 1-8 would be entered under the diagnosis index # column.
 59. Examination and treatment plan: Use the American Dental Association's *Current Dental Terminology (CDT-3)* for appropriate procedure codes. If a procedure is performed multiple times, record the procedure code once and the frequency in the quantity (Qty) column. When completing the diagnosis index # column, enter the index # (1-8) for as many diagnoses as necessary for each procedure code. When a patient has more than one diagnosis per procedure, separate index number with comma.
 60. Identify all missing teeth with "x".
 61. Remarks for unusual services: Use to indicate any information that you feel may be helpful in determining the benefits for the treatment.
 62. Dentist's signature block: The treating dentist's signature and license number. Dentist should be aware that they may have ethical and legal obligations to refund fees for services that are paid in advance but not completed.
 - 63-66. Address where treatment was preformed: Necessary if the treatment was preformed at a different location than indicated in boxes #46,50-52.
- For administrative use only: Area where carrier calculates benefits.

ORTHOBANC, LLC RECURRING PROGRESS PAYMENT PLAN

Orthodontist Dr. Robert M. Amason

Account # _____

Responsible Name:	Patient Name:
Responsible Address:	Responsible SSN:
City, State, Zip:	Email:
Home #	Work #

Amount of Total Withdrawal	Monthly Payment Amount	Final Payment Amount	Total Number of Monthly Withdrawals	Withdrawal Begin Date		
				Month	Day	Year
					5 12	19 26

ORTHOBANC, LLC EFT AUTHORIZATION

I hereby authorize OrthoBanc, LLC (hereafter referred to as "OrthoBanc"), on behalf of the Orthodontist, to initiate debit entries to the account (s) indicated below via electronic funds transfer (EFT). I hereby authorize the financial institution(s) named below to accept and honor EFT withdrawals by OrthoBanc. I understand that beginning on the date listed above, OrthoBanc will begin withdrawals from my bank or credit card account. Such withdrawals will continue each month until the entire balance, provided to OrthoBanc by the Orthodontist, is paid in full. I understand that OrthoBanc is debiting funds from my account for payment to the Orthodontist and that the name OrthoBanc may/will appear on my monthly statement. I understand my final payment may be slightly more or less than the Monthly Payment Amount listed above, but will not exceed the balance of the account. Should the Orthodontist need to reduce the amount of my debit, the Orthodontist may notify OrthoBanc to reduce the Monthly Payment Amount without notification to me.

I further agree that should OrthoBanc be notified that funds are not available in my bank account (NSF, closed account, etc.) or that a charge to my bankcard is denied, a \$20 fee will be charged by OrthoBanc. I agree that if funds are not available from the account I choose as primary, OrthoBanc can attempt to secure funds from my secondary account. If no secondary account is provided, OrthoBanc can re-draft my primary account. I understand that if I choose to discontinue this method of payment I must notify OrthoBanc, a minimum of 7 days prior to my scheduled debit date.

Please select the primary and secondary accounts OrthoBanc is to debit:

Primary Account	Secondary Account
<input type="checkbox"/> Checking * <input type="checkbox"/> Savings _____ Name(s) as it appears on your account _____ Bank Account # Routing #	<input type="checkbox"/> Checking * <input type="checkbox"/> Savings _____ Name(s) as it appears on your account _____ Bank Account # Routing #
<input type="checkbox"/> Credit Card * Card Type _____ Credit Card # _____ Expiration Date _____	<input type="checkbox"/> Credit Card * Card Type _____ Credit Card # _____ Expiration Date _____

Signature: _____ Date: _____

SSN: _____

For Orthodontist use only:		For OrthoBanc, LLC use only:	
PID Number:	Patient OrthoBanc Ref No	Received:	Initials
of00001765/op00001889			