CONSENT

PART (1) This section must be completed for all patients:

PATIENT NAME: _____ **(Preferred Name):** _____ **M ☐ F ☐ X ☐**

If patient is 19 years or younger: Parent/ Guarantor Name:_____

HEALTH CARD NUMBER/ EXPIRY DATE: _____

FULL ADDRESS: _____ City: _____ Postal Code: _____

TELEPHONE: Home: _____ Cell: _____ Work: _____
EMAIL: _____ (*I Consent To Electronic Communications*)

PLEASE SIGN BELOW TO ASSUME RESPONSIBILITY FOR ALL FEES ASSOCIATED WITH THE TREATMENT PROVIDED AND I UNDERSTAND THAT FEES MAY NOT BE COVERED BY INSURANCE BENEFITS
FAILURE TO PAY WITHIN 3 MONTHS WILL RESULT IN AUTOMATIC REFERRAL TO COLLECTION AGENCY.

Signature of Patient, Parent or Guardian: **X** _____

PART (2) If insurance coverage is applicable, sign this section to authorize claims and your information below:

INSURANCE PLAN#1
Insurance Company: _____
Group/Policy Number: _____
ID/ Certificate Number: _____
Policy Holder Name: _____
Policy Holder Date of Birth: _____
Relation to Policy Holder: _____

INSURANCE PLAN #2
Insurance Company: _____
Group/ Policy Number: _____
ID/ Certificate Number: _____
Policy Holder Name: _____
Policy Holder Date of Birth: _____
Relation to Policy Holder: _____

PLEASE SIGN BELOW IF YOU AUTHORIZE THE POINTS FOR INSURANCE:

1. I authorize release to the dental benefits plan administrator and the CDA, information contained in claims submitted electronically.
2. I authorize the communication of information related to the coverage of services described to the providers of Atlantic Oral Surgery.
3. I hereby assign my benefits, payable from claims submitted electronically to the provider of Atlantic Oral Surgery and authorize payment directly to Atlantic Oral Surgery.

Signature of Patient, Parent or Guardian: **X** _____

PART (3) This section must be signed for all patients:

1. ACKNOWLEDGEMENT OF PRIVACY STATEMENT

Having read and understood the *Privacy Statement for Patients*, I hereby consent to the collection, use and disclosure of my personal information as presented in the *Statement*.

Please list here ONLY if you have restrictions:

- RESTRICTED ACCESS- My personal information shall NOT be provided to the following individuals or organizations:
  _____
- RESTRICTED INFORMATION- Personal information disclosed shall NOT include my following personal information:
  _____

2. AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I give permission to health care institutions to release my personal health information gathered prior to, as well as after the date of signature below. I may withdraw my permission at any time, in writing, as long as the information has not already been released. I may also indicate an expiry date for this authorization.

(If you are requesting an expiry, please indicate a specific Authorization Expiry Date: _____)

Signature of Patient, Parent or Guardian: **X** _____

DATE: _____