Patient's Name:

PRIMARY DENTAL			
Subscriber's Name:	Relationship to you:	Employer:	
Insurance Company:	Insurance address:		
Insurance phone:	Member ID/SS#:	Group#:	Member Date of Birth:

SECONDARY DENTAL			
Subscriber's Name:	Relationship to you:	Employer:	
Insurance Company:	Insurance address:		
Insurance phone:	Member ID/SS#:	Group#:	Member Date of Birth:

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on my claim. I request the payment of authorized benefits be made on my behalf. I assign benefits payable to this practice. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges, whether or not paid by said insurance.

Signature of responsible party: _____ Date: _____

If eligible for Medicare/Medicaid, please review the following:

I understand that Dr. Craig Meadows has opted out of the Medicare/Medicaid program. I accept full responsibility for payment of his charges for all services provided by his office. I agree not to submit a claim to Medicare or ask Dr. Meadows to submit a claim to Medicare. I understand I have the right to obtain Medicare-covered services from physicians who have not opted out of Medicare.

Patient Signature: _____ Date: _____

PATIENT INFORMATION		
Emergency Contact:	Relationship to you:	Phone:
Referring Dentist:	City/State:	

HIPAA ACKNOWLEDGEMENT

Please review the Patient Consent for Use and Disclosure of Protected Health Information on the reverse and sign below.

Patient Signature: _____ Date: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, the practice may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to read the Notice of Privacy Practices before deciding whether to sign this consent. The Notice provides a description of treatment, payment activities, and healthcare operations of the uses and disclosures that may be made of my protected health information, and of other important matters about my protected health information. A copy of the Notice if available upon request.

With my consent, the practice may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care.

With my consent, the practice may mail to my home or other designated location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that the practice restrict it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting the practice's use and disclosure of my PHI to carry out TPO.

I have the right to revoke this Consent at any time by giving the practice written notice of my revocation. Please understand that revocation of this Consent will not affect any action taken in reliance on this Consent before revocation was received, and that the practice may decline to treat me or to continue treating me if this Consent is revoked.