



HIPPA CONSENT FORM

Patient Name: _____

Phone: _____

HIPPA – NOTICE OF PRIVACY PRACTICE

HIPPA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Natural Smiles Dental Care may use or disclose your health care information. The notice also explains the rights that you are guaranteed under the HIPPA regulations. We are required by the HIPPA privacy rule to distribute this notice to you and obtain acknowledgement that you have received the notice. Signing below indicates that you have received the notice of privacy practice. If you have any questions, please contact our HIPPA compliance officer with any questions.

I hereby acknowledge that I have received a copy of Natrual Smiles Dental Care’s Notice of Privacy Practices.

Patient Signature: _____

Date: _____

PERMISSION TO SHARE MEDICAL INFORMATION

My medical and dental information may be obtained and exchanged verbally with:

Name/Relationship: _____

Initials: _____
(of patient or guardian)

PERMISSION TO BILL INSURANCE

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.

Signature: _____

Date: _____

4700 Lexington Ave N, Suite D
Shoreview, MN 55126

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