PATIENT CONSENT FORM

Smile Center of Orlando
3710 Aloma Avenue
Winter Park, FL 32792
(407) 678-8848

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.

Authorization: I authorize a family member to make or verify appointments on my behalf, as well as, authorize a family member to verify and/or discuss account history information including, but not limited to, treatment fees & plans, insurance claims and payment activities. I give permission to the Smile Center of Orlando to either manually confirm my dental/ortho appointment and/or utilize the automated appointment confirmation system, to leave a message regarding my appointment. I also give permission to use photographs of me and/or my smile for the purpose of before & after photos and internal marketing purposes. My personal information will not be distributed or sold to any companies for other solicitation purposes.

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 matter about your protected health information. A copy of our Notice accompanies this Consent as well as it is posted in our office. 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 post the revised Notice of Privacy Practices, which will contain the changes, and you will be able to request a copy of the revised Notice at any time. Those changes may apply to any of your protected health information that we maintain.

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 Privacy Officer of the Smile Center of Orlando. 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.

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 use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient Name: ______________________________ Signature: __________________________________

Today's Date: _____________________________

Notice of Privacy Practices Acknowledgement: I have received a copy of this Office's Notice of Privacy Practices.

Patient Signature: ______________________________________

Office Representative: ____________________________ Relationship to Patient: Staff Member

You may refuse to sign this Acknowledgement, however, if this Acknowledgement is not signed, we may decline to treat you or to continue treating you.

July 2006