AHWATUKEE
FAMILY DENTAL
Family and Cosmetic Dentistry

Patient Name: _____

Social Security Number: _____

Date of Birth: _____

CONSENT, AUTHORIZATION & ACKNOWLEDGEMENT FORM

CLINICAL: I, the undersigned, hereby authorize Dr. Rush and Staff to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Rush to make a thorough diagnosis of my own or my dependant's dental needs. I also authorize Dr. Rush to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand that the use of anesthetic agents, sedatives and other medications embody a certain risk.

INITIALS: _____

FINANCIAL: I understand that I am responsible for payment for all services rendered on my behalf and my dependants. I have been informed that payment is due when services are rendered. I am aware that a 18% APR is automatically tabulated into my account if my balance is 90 days old or older. Should my account become delinquent, I will assume all additional collection costs and legal fees. I understand that where appropriate, credit reports may be obtained. Our No Show Policy states that if a patient has more than 2 missed, failed, no-showed or last minute cancellations within a 6 month period we have the right to dismiss this patient from our practice, in addition to charging a No-Show Fee. A $75 Broken Appointment Fee may be charged to my account for all broken and/or last minute cancellations or reschedules. I am aware that to hold down operating costs, a minimum 48 business hours notice of cancellation is required. There is a $25 charge to duplicate all records and a $20 charge to duplicate X-rays.

INITIALS: _____

INSURANCE: I authorize this practice to release to staff, hospitals, health care service plans, insurance companies, self- insurers or their representatives, any and all information, records and radiographs about my medical history, services rendered and treatment necessary. I authorize this practice to submit claims for payment for services rendered or pre- authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to this practice the insurance benefits providing assignment is accepted. Any payments received by Dr. Rush from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and Dr. Rush, and that I am still fully responsible for all dental fees whether or not my insurance carrier makes any payments on my behalf. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I understand I am responsible for the deductible, co-payment and excess over maximum allowed the day of services.

INITIALS: _____

DENTAL MATERIALS FACT SHEET: I acknowledge receipt of a copy of the Dental Materials FactSheet as required by law, as created by the Dental Board of California and as made available by the Arizona Board of Dental Examiners to their licensed dental providers. I understand that this data was given to me by my Dentist in the effort to increase my knowledge regarding materials used in my dental treatment. I understand that these documents are meant to facilitate discussion between my Dentist and myself regarding dental materials. I understand that the information contained in these documents reflect the position and opinion of the Dental Board of California and may not reflect those of Dr. David Rush, DDS and staff. I am aware that Dr. Rush and the Arizona Board of Dental Examiners are available to answer any further questions I may have regarding dental materials and their use.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA): I understand that by signing this form I am consenting to use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. I understand that I have the right to refuse to sign this Acknowledgment.

INITIALS: _____

AHWATUKEE FAMILY DENTAL
4350 E. RAY ROAD
BLDG 3, SUITE 112
PHOENIX, AZ 85044
480-893-7674

FULTON RANCH DENTAL
4909 S. ALMA SCHOOL RD
CHANDLER, ARIZONA
85248
480-895-7070

INFO@RUSHFAMILYDENTAL.COM

WWW.AHWATUKEEFAMILYDENTAL.COM

AHWATUKEE
FAMILY DENTAL
Family and Cosmetic Dentistry

CONT. CONSENT, AUTHORIZATION & ACKNOWLEDGEMENT FORM

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:

Dr. Kyle Rush, DDS or Dr. Cory Rush, DDS HIPAA Officer
4909 So. Alma School Rd. Chandler, AZ 85248 (480) 895-7070

Dr. Kyle Rush, DDS or Dr. Cory Rush, DDS HIPAA Officer
11022 So. 51st St., Ste #105 Phoenix, AZ 85044
(480) 480-893-7674 E-mail: Info@rushfamilydental.com

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. I have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I hereby authorize, as indicated by my signature below, to use and disclose my protected health information to carry out treatment payment activities and health care operations.
Signatures below indicate that I have read this entire document and fully understand the contents of this Consent / Authorization / Acknowledgment. I have been provided with the opportunity to ask questions and obtain further clarification.

PATIENT Signature (Parent of Child): _____ DATE: _____
RELATIONSHIP: _____

If a personal representative, other than a parent to a minor, on behalf of the patient signs this Consent, please complete the following:
Personal Representative's Name: _____ DATE: _____
RELATIONSHIP: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
(Include original completed Consent form in the patient's chart)

REVOCATION 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.

PATIENT Signature (Parent of Child): _____ DATE: _____
RELATIONSHIP: _____