Phone: 512-937-3371 / 512-456-7583
Email: info@lakelinefamilydental.com
Website: www.lakelinefamilydental.com
Address: 1201 N Lakeline Blvd, Suite 300
Cedar Park, Texas 78613

Consent for Services and Financial Information and HIPAA Information

Consent:
I hereby authorize Dr. Prakash and/or his staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate by Dr. Prakash to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Dr. Prakash to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks

Financial Information:
As a courtesy, this office will help prepare and submit your insurance forms, however I understand that any fees not covered by insurance are my final responsibility. By signing this form I authorize this office to submit insurance claims and to contact my insurance company on my behalf. In consideration for the professional services rendered to me or at my request, I agree to pay for all services regardless of insurance coverage. I understand that any fee estimate provided by this office for my dental care is only extended for a period of ninety (90) days from the date of the patient examination. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. I understand that payment plans are available to assist with payment. I understand that in order to be approved for any payment plan options that a credit report may be run. I understand that in the event that I default in the payment of fees due to Dr. Prakash, I will be responsible for all expenses incurred by Dr. Prakash including, but not limited to attorney fees, collection expenses, discretionary costs and court costs associated with collecting outstanding fees. I also understand that negative payment information may be reported to credit agencies.

HIPAA Information:
I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); obtaining payment from third party payers (e.g. my insurance company); the day-to-day healthcare operations of your practice. I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and
health care options, but that you are not required to agree to these requested restrictions. However, if you do agree, you are than bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party