

FINANCIAL AND TREATMENT CONSENT FORM

If insurance applies, I authorize and hereby request my insurance company to pay directly to the dentist. I understand that my dental insurance may pay less than the actual bill for services. I understand that quotes from this dental office are only estimates, not a guarantee of coverage and my insurance may pay more or less. I agree to be responsible for payment of all services on my behalf or my dependents.

By signing, this also gives consent for treatment by Dr. Dennis Jenkins and the Designing Smiles Team.

Signature of patient or guardian: _____ Date: _____

PATIENT CONSENT / ACKNOWLEDGMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Designing Smiles, P.S.C., our team, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Privacy Practices. You have the right to review our Notice of Privacy Practices prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting Designing Smiles, P.S.C. at (812) 246-3386. You have the right to request that we restrict our uses or disclosures of your protected health information which we are otherwise permitted to make for treatment, payment, and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information.

You may disclose information to my family members and or non-family members. The following persons are listed below:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

You may leave Protected Health Information on my answering machine / voice mail.

I HAVE REVIEWED, UNDERSTAND, AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

Print Name: _____ Signature: _____ Date: _____

PHOTOGRAPHY CONSENT FORM

Please check any area that you would allow Dr. Jenkins and Designing Smiles to use photographs, radiographs and or study models for any of the following: advertisement patient education cosmetic dentistry presentations teaching

Please check any section that you would **NOT** like us to use: full face photos teeth only photos
 x-rays study models