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**Dr. Tsur-Tsar**

603 Village Blvd. Suite 304

West Palm Beach, FL 33409

561-855-4703

**“PRIVACY RULE” CONSENT FORM**

The department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. It was also created to provide a standard for certain healthcare providers to obtain the patients’ consent to use and disclose health information to carry out treatment and insure payment.

We respect your right to the privacy of your personal dental records and will do all we can to secure and protect them. However, in some instances it may become necessary to release information to laboratories, pharmacies or other physicians in order to fulfill our commitment to maintain your health. Be assured, you have our full support to access your own records any time we are available. By signing this consent form, you are giving us permission to release certain information for the reasons mentioned above. It also allows us to mail reminder cards addressed to you and leave messages on your voice mail regarding your appointments or account. You have the right to revoke your consent at any time with a written and signed notice.

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**Signature of patient, parent, guardian or personal representative Date**

**DENTAL BENEFIT EXPLANATION & AGREEMENT**

It is our policy to provide the best dentistry for you. To do this, it is important that we do not allow dental benefits to be a determining factor in the diagnosis. Your treatment will be based upon your needs, and we assume that you are concerned as we are about maintaining your good health. Generally, dental benefits pay a percentage of each procedure up to a set yearly maximum. The benefits available to you are established by the plan package your employer purchased. **As a courtesy to you, we will submit claims to your dental plan carrier. We also accept benefit assignment, meaning that we will estimate the expected benefit payment and allow you to pay your estimated portion at the time services are provided. \*However, we do not guarantee any estimate, and should your dental plan pay less than expected, you are fully responsible for the balance. We take no responsibility for any denials by dental plans.\***

I also agree to these policies regarding my dental benefits and will be held responsible for the entire balance for services rendered after 45 days of service if my dental insurance has not paid A.P. Dental Arts or Dr. Valeriy Tsur-Tsar directly.

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**Signature of patient, parent, guardian or personal representative Date**

**FINANCIAL AGREEMENT FOR SELF PAY**

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services or items provided to me, to my minor/ child. I accept full financial responsibility for all charges for services or items provided to me, to my minor child, or to the patient for whom I have legal responsibility.

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**Signature of patient, parent, guardian or personal representative Date**