Ravi Doctor DDS

Health Insurance Portability & Accountability Act Consent Form (HIPAA)

Due to the health insurance portability and accountability act, our office is now required to give all patients the ability to obtain a copy of our privacy policy. It informs you how we use and disclose your health information for treatment, payment, and healthcare operations. This will be done at the patient's request. A copy of our policy will be available in the office reception room for patients to review. Please sigh this as your acknowledgement that this office is following HIPAA policy requirements.

By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have a right to read our Notice of Privacy Practices before you decide whether to sign this consent. You will have the right to evoke this consent at any time by giving us written notice of you revocation by certified mail.

Please initial the following statements:

____ Protected information may be disclosed or used for treatment, payment, or healthcare operations.
____ The practice has a Notice of Privacy Practices and I have had the opportunity to review that notice.
____ The practice reserves the right to change the Notice of Privacy Policies.
____ Patients have the right to restrict the uses of their information, but the practice does not have to agree to those restrictions.
____ The patient may revoke this consent in writing at any time and all future disclosures will then cease.
____ The practice may condition treatment based on the execution of this consent.

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In order to insure the accuracy of your protected health information, it is our office policy to update this form annually

I authorize Ravi Doctor DDS and his employees to release my dental or insurance information as necessary to process my dental claims and coordinate or manage my dental care.

In the event that a family member or caregiver attends my dental visit and is in the exam room at the time of my evaluation or treatment, I give Ravi Doctor DDS and his employees my permission to discuss freely, my condition, treatment, financial terms, or diagnosis with that person.

Home Phone: ( ) _____ May we leave a message? ○ YES / NO ○

Work Phone: ( ) _____ May we leave a message? ○ YES / NO ○

Cell Phone: ( ) _____ May we leave a message? ○ YES / NO ○

Email: _____ May we send a message? ○ YES / NO ○

List names of those we may discuss issues relating to diagnosis, treatment, and financial arrangements: _____

_____

List names & phone numbers of those we may contact in case of an emergency: _____

_____

List the address where billing statements & other correspondence may be sent: _____

Printed name of patient: _____

Date: _____ Signature: _____ Relationship to patient: _____

Southlake Office: 261 East Southlake Blvd., #100 Southlake, TX 76092 817-328-2400

Arlington Office: 1810-A South Bowen Rd. Arlington, TX 76013 817-274-8667

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