PAUL D. NIFONG, JR., DDS PA
FAMILY, COSMETIC & IMPLANT DENTISTRY

Health Care Consent & Authorization Form

FINANCIAL RESPOSIBILITY: I do hereby expressly agree to pay and guarantee payment in full of any charges for services rendered or to be rendered to the below named patient by Paul D. Nifong, Jr. DDS PA (PNDDS) and by licensed healthcare providers or their professional entities who may provide services during this patient visit. Payment is due in full within 30 days of services. In the event of nonpayment, the undersigned guarantees payment of late charges not to exceed 1.5% per month for bills 30 days past due and all costs of collections, including reasonable attorney's fees. In addition, I authorize the transfer of monies paid to PNDDS or on behalf of the patient and otherwise refundable to the patient or guarantor, to other accounts at PNDDS for which the patient is responsible.

Signature:_____ Witness:_____

ASSIGNMENT OF INSURANCE BENEFITS: I authorize payment of dental benefits payable to me directly to PNDDS. I understand that Billing of Insurance is a service only and not a guarantee of payment. If my insurance requires pre-certification for services, I realize it may be my responsibility to get the necessary approvals. I understand that I am personally responsible to PNDDS for charges not covered by insurance, including charges for health care services determined to be non-dental necessary by a private insurer's utilization review program. I understand that I may choose to continue services that are not covered by the patient's insurance carrier at my own expense.

PERSONAL VALUABLES: PNDDS is not responsible for the personal property or valuables of patients. I release PNDDS of all responsibility for personal property and valuables.

AUTHORIZATION FOR CARE AND/OR TREATMENT: I hereby consent to specialist outpatient treatment and give permission to PNDDS to provide the services deemed necessary or advisable in the diagnosis and treatment of this patient. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatment or examination in PNDDS. I understand that the provider may give dental services that are deemed necessary or advisable to the patient without a written consent form.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR PAYMENT PURPOSES: I authorize PNDDS to furnish any information relating to this treatment to representatives of any party financially responsible for the patient's care or to any governmental or charitable agencies. I understand that only that information that is necessary for payment purposes will be disclosed.

RELEASE FOR TREATMENT/QUALITY REVIEW PURPOSES: I authorize release of dental information about the patient to the referring specialist, any dental care facility or physician to whom the patient may be referred and any extended care facility considered for treatment. I understand that a separate consent form is necessary for disclosure of information regarding treatment of alcohol or substance abuse. I specifically consent to the disclosure of information related to AIDS, HIV infection or other communicable diseases.

MY SIGNATURE BELOW INDICATES APPROVAL OF THE ABOVE UNLESS OTHERWISE MARKED THROUGH AND INITIALED.

Signature:_____ Witness:_____

Date:_____

If the patient is unable to consent or is a minor, complete the following:

Patient is unable to consent because_____
and I confirm that I am authorized to consent on the patient's behalf:

_____ Date:_____
Responsible Party

PRINT PATIENT'S NAME:_____