Grant D. Ringler, DDS
Justin L. Barnhart, DDS
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3008 Garden Grove Parkway
Hutchinson, KS 67502
620.669.0835 Office
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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Section B: To the Patient - Please Read The Following Statements Carefully

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry on treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: The Health Insurance Portability & Accountability Act of 1996 is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required to maintain the privacy of our health information how it is used and disclosed.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, if we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at anytime through designated contact personnel.

Contact personnel:
Mel Whitmore
620-669-0835

I understand that, under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

The completed Consent will be maintained in the patients record.
You are entitled to a copy of this Consent after you sign it.

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Financial Policy and Consent for Services at Grant D. Ringler, DDS

We would like to thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. The following is a statement of our financial policy and consent for services.

Patients with Insurance:
Please have your correct insurance card available for us to photocopy so we will be able to confirm your dental benefit coverage. We will provide you with an estimate for your co-payment amount and expect that estimated portion to be paid today. Any delay in obtaining sufficient information may result in consultation and/or treatment to be rescheduled. If we cannot confirm your dental benefits, we will ask for full payment. Once provided with the correct information, we can then file the insurance for your reimbursement. We would be happy to complete your insurance form in an acceptable way that receives the best return for you. However, this does not absolve the patient of the full responsibility for the charges. The estimate provided by our office is to be considered as a guideline only until the final insurance payment is received and your account reconciled.

Patients without Insurance:
If you currently do not have insurance, we can provide you with an estimate of the charges prior to our initial consultation by the doctor. The estimate may vary depending upon the final diagnosis and type of treatment rendered. The full balance is expected to be paid at time of service.

Financing is available for extensive dental treatment to those who qualify. We will be happy to consult with you on this method of payment. In the event a legal suit or should outside collections become necessary to enforce payment of the account, the patient agrees to pay for all collection fees and/or attorney's fees in addition to court cost as may be deemed reasonable.

To accommodate you, we accept the following methods of payment: Cash, Check, Master Card, Visa, Discover, American Express, Care Credit, and Lending Club.

Consent of Service
There is no assurance of success that has been or can be given in dental treatment. There is always the possibility that further treatment may be necessary which may result in additional charges. In signing below you acknowledge full responsibility for the payment of all necessary services on the date treatment is started.

I understand that a specific amount of time is allotted for my visit. I understand if I need to cancel my appointment, I need to inform the office with 24-hour notice.

I have read, understood, and agree to the above financial policy and consent of services.

_____ Date: _____
Signature of Patient and/or Responsible Party