**Shelly L Boss DDS Inc.**

4097 Fulton Dr NW - Canton OH 44718

**PATIENT AUTHORIZATIONS**

Please initial

\_\_\_\_\_ I authorize the release of my dental records from Shelly Boss DDS Inc. and/or individuals involved in my dental care. I further authorize the release of records from any individuals to Shelly Boss DDS Inc.

\_\_\_\_\_ I authorize insurance payments to be made directly to Shelly Boss DDS Inc. I understand that I am responsible for any unpaid balance and may be charged finance/attorney fees in attempt to recover balance. I have read and agree to the terms of the financial policy.

\_\_\_\_\_ I am aware that I should provide adequate notice to change an appt, and I may be charged a fee due to late cancelation or no show.

\_\_\_\_\_ I am aware of and have received notice of the Health Insurance Portability and Accountability Act (HIPAA). I understand you may decline to treat me if I revoke my consent.

**Notice of Privacy Practice- Acknowledgment**

We keep record of the health care services we provide for you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or the law authorizes or compels us to do so.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

**By my signature below I acknowledge receipt of the Notice of Privacy Practices.**

**Authorization for Appointment Confirmations & Office Communications**

As a courtesy to our patients, we often give a variety of appt reminders. Some of those reminders may generally include but are not limited to, post-cards sent through mail, messages left with family, voicemails, text messages and emails. Usually within these messages a certain amount of specific information, consisting of patients appt time and date, or need for appt are included.

**By my signature below, I authorize Shelly Boss DDS Inc and staff to confirm my appt and remind me of the need for one by any of the above-mentioned ways, for the duration of my treatment with this office.**

**Authorization to discuss Treatment & Financial Information**

By my signature below, I authorize Shelly Boss DDS Inc and staff to discuss my treatment and financial information with the people named below.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patients Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_