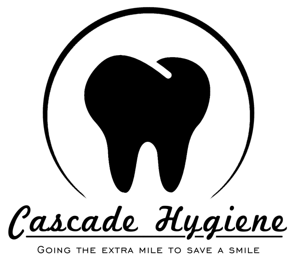

Consent For Treatment

PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can access this information. Please review it carefully.

In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability act of 1996 (HIPPA), we are required to maintain the confidentiality of your health information. This describes how we may use and disclose your protected health information to carry out treatment, payment of health care and for other purposes that we are permitted or required by law. We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. For example: your health/dental information may be provided to a dentist to whom you have been referred. In addition, we may disclose your protected health information periodically to another dentist, physician, or health care provider who becomes involved in your care. We may use and disclose dental information about you in order to obtain payment for services rendered. Such disclosures may be made to you, responsible party or third party.

Patient Information

Name ______________________ Date of Birth ____________ Care Facility ______________________

Facility / Home Address ____

City ______________________________ State ____________ Zip ______________

Facility / Contact Person ______________________ Facility / Home Phone ______________________

Medical Information

Physician's Name ____

Physician's Phone ______________________ Physician's Fax ______________________

Dentist's Name ____

Dentist's Phone ______________________ Dentist's Fax ______________________

Is the patient required to take an antibiotic prior to treatment? ☐ YES (See below) ☐ NO

Medication ______________________ Reason Needed ______________________

Responsible Party

Name ______________________________ Relationship to Patient ______________________

Phone ______________________ Email ________________________________

Mailing / Billing Address ____

City ______________________________ State ____________ Zip ______________

Permission is granted for review of Medical Records / Permission is granted to take picture of patient for chart ID and educational purposes. *All fees are ultimately the responsibility of the "Responsible Party."*

Signature of Responsible Party ________________________________ **Date** ______________

Please return this form to: cascadehygiene@gmail.com

Cascade Hygiene provides mobile dental care to people who are unable to travel to the dental office.

cascadehygiene.com | (360) 362-0151 | PO BOX 5842 Bremerton, WA 98312