Cascade Hygiene
Going the extra mile to save a smile

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 (HIPAA), 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