JOHN R. LINDEMAN, D.D.S.

HIPPA CONTACT AND CONSENT

CONSENT:

1. The undersigned hereby authorizes the doctor, doctor's assistant and/or hygienist to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make thorough diagnosis of the patient's dental needs.

2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connections with (**print name of patient**) ____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that Dr. Lindeman choose and employ such assistance as deemed fit to provide recommended treatment.
3. Persons authorized to receive my dental health information (full name, relationship, and phone number):

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER

4. Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed-upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collections costs and reasonable attorney fees as may be required to effect collection of this note. I also understand that a fee will be charged for failed appointments and/or cancelled with less than 24 hours notice.
5. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
6. I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

Patient Signature: ____ DOB: __________________ Date: _____________

Parent/Responsible Party Signature: ____________________________________ Relationship to Patient: ___________

Dr. Lindeman and/or his staff members may notify me with appointment reminders and other information regarding my dental health as follows: (circle all that apply)

Leave messages on voice mail:	HOME	WORK	CELL
Leave message with co-worker:	YES NO		
Text Message:	YES NO		

Email address: ____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Team Member Signature: ____ Date: __________________________________