**JOSEPH J THOMAS D.D.S., PA**

**GENERAL DENTISTRY**

INITIATION OF SERVICES, GENERAL RELEASE, and ACKNOWLEDGEMENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, OBTAINING PAYMENT OR OTHER HEALTH CARE OPERATIONS

**FLORIDA AND FEDERAL LAW REQUIRES THAT INFORMATION CONTAINED IN YOUR MEDICAL RECORDS BE HELD IN STRICT CONFIDENCE AND NOT BE RELEASED WITHOUT YOUR WRITTEN CONSENT. THE CONSENT YOU SIGN ON THIS PAGE WILL REMAIN IN EFFECT UNTIL YOU REQUEST IN WRITING THAT YOUR CONSENT BE WITHDRAWN, WHICH YOU MAY DO AT ANY TIME. YOU HAVE A RIGHT TO REQUEST AND OBTAIN A COPY OF THIS CONSENT.**

PART I - **CONSENT TO RELEASE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of Patient/Parent) do hereby consent that **Joseph J. Thomas D.D.S., PA,** located at 680 Royal Palm Blvd., Vero Beach, FL 32960/4125 9th Street SW, Vero Beach, FL 32968/4719 North Ocean Drive, Ft. Lauderdale, FL 33308 and any physician or health care Provider/Dentist or authorized agent, examining or treating me to use or disclose protected health information for treatment, payment, or health care operations, including release to dental laboratories and any third party payer, any medical, psychiatric/psychological, alcohol/drug abuse, sexually transmitted diseases, tuberculosis, AIDS, HIV, or case management information, including any information received from other health care Providers, concerning diagnosis and treatment for its use in determining claim for such diagnosis or treatment. This may include any and all information pertaining to payment.

PART II - **INSURANCE/MEDICARE PATIENT CERTIFICATION AUTHORIZATION TO RELEASE AND PAYMENT REQUEST- JOSEPH J. THOMAS, D.D.S., PA** is **NOT** a MEDICARE/MEDICAID PROVIDER \_\_\_\_\_\_ (Patient’s initials)

PART III - **ASSIGNMENT OF BENEFITS**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby assign to **Joseph J. Thomas, D.D.S., PA**  all benefits provided under any Insurance, health care plan, dental plan/policy, or medical expense policy for dentally related services provided for me. The amount of such benefits shall not exceed the dental/surgical charges set forth by **Joseph J. Thomas D.D.S, PA.** All payments under this paragraph are to be made to **Joseph J. Thomas D.D.S., PA.** I am personally liable and fully responsible for **ANY** and **ALL** charges not covered/reimbursed by this assignment to **Joseph J. Thomas D.D.S., PA**.

PART IV - **BY MY SIGNATURE BELOW, I ACKNOWLEDGE THE ABOVE AND ACCEPT FULL FINANCIAL RESPONSIBILITY, AND RECEIPT OF THE COPY OF THE NOTICE OF PRIVACY RIGHTS.**

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Patient/Parent/Representative Signature Relationship to Patient Date