ROCKY TOP DENTISTRY, PLLC
HIPPA DISCLOSURE, ACKNOWLEGEMENT, AND CONSENT

Purpose of Consent: By signing this form, you will consent to our use of your protected health information to carry out treatment, payment activities, insurance filing, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information. A copy of our Notice is available for you. We encourage you read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we maintain.

You may obtain a copy of Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Dr. Leslie Holmes-Leach, D.M.D., P.O. Box 599, 305 South Main Street, Rocky Top, TN, 37769, phone 865-426-7421.

Right to Revoke: You have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the person listed above. Please understand that the revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

By signing below you acknowledge that you have had the opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that by signing this form, I am giving my consent for Rocky Top Dentistry and its associates to use and disclose my protected health information to carry out treatment, payment activities, insurance filing, and healthcare operations.

INSURANCE CLAIM FILING

By signing below, I give Rocky Top Dentistry and associates permission to file my dental insurance for payment of services rendered. I acknowledge that this does not guarantee payment and I am responsible for all fees not covered by insurance.

PATIENT INFORMATION/ MEDICAL HISTORY

To the best of my knowledge, all my patient information and medical history questions have been accurately answered. I understand that providing incorrect information can be dangerous to my (patient's) health. It is my responsibility to inform the dental office of any changes in my medical status. By signing below I acknowledge the above and give Rocky Top Dentistry and associates permission to photograph and use for educational purposes any aspect of my dental condition or treatment procedures, and further allow him permission to discuss my condition(s) with my physician or health care provider and request information from them.

APPOINTMENT POLICIES/REMINDERS

I acknowledge that this office sends appointment confirmations by mail and phone, and may leave messages on answering machines and with family members. I will notify this office in writing if I do not want such confirmations.

By signing below, I acknowledge and agree to all the above conditions.

Patient Name (print) _____ Date Of Birth_____

Signature: _____ Date:_____

Relationship if patient is a minor:_____