North Hills Implant & Oral Surgery
3809 Computer Drive, Suite 101
Raleigh, NC 27609

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information as is required to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day-to-day healthcare operations at North Hills Implant & Oral Surgery

I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health protected information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most recent copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

With whom (family members or friends) may we share information about your treatment and account:

_____ Relationship to patient_____

_____ Relationship to patient_____

Emergency Contact Name: _____

Relation to patient_____ Ph. Number: _____

I consent that North Hills Implant & Oral Surgery may leave messages regarding my account, including but not limited to, financial information and appointments, using the following contact information:

Home:_____ Cell:_____

Email: _____Text_____

Printed Patient Name:_____ Date:_____

Patient Signature:_____

If patient is a minor:

Patient Guardian Signature:_____ Date:_____

Print Guardian Name;_____ Relationship to Patient:_____