MYLENE GLUECKERT REINICKE, DDS | 719.597.6300
2960 NORTH CIRCLE DRIVE | SUITE 105 | COLORADO SPRINGS, 80909

PATIENT NAME:	DATE:

GENERAL PATIENT CONSENT

- I verify that I have reviewed the information on the reverse side, and that it is correct.
- I hereby authorize **Dr. Mylene Glueckert Reinicke and personnel to deliver dental treatment and care** to myself and my dependents listed. I understand that treatment may include the administration of local anesthetics, surgical procedures and the use of various dental materials.
- I understand that as a courtesy, that Audubon Dental, PC will file a claim with my primary insurance, but it is my responsibility to ensure payment. If I have insurance that Audubon Dental, PC is contracted with, I authorize assignment of payments directly to my provider for services provided to me.
- I understand that, under the terms of the contract that I have with my insurance company, I must pay any predetermined or estimated co-payments at the time of service.
- I understand that Audubon Dental, PC will file a claim with my insurance company and that I am responsible for following up with my insurance company to insure my claim is paid within 60 days of my visit date. I understand that Audubon Dental, PC cannot act as an intermediary between myself and my insurance carrier to effect payment.
- I understand that if my insurance claim is denied, I will be billed and payment in full will be due immediately.
- Because I have reserved time for treatment, I understand that a **$55.00 fee will be charged per hour for appointments missed or cancelled** without at least **24 hours advance** notice.
- I understand that **for dependent children**, the responsibility of payment whose parents are divorced rests with the parent who seeks treatment for the child. Any court ordered responsibility judgment must be determined between the individuals involved without inclusion of our office.

Patient Signature:	Date:

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- With my consent, Audubon Dental, PC may use and disclose information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Audubon Dental, PC's Notice of Privacy Practices for a more complete description of such uses and disclosures.
- I have the right to review the Notice of Privacy Practices prior to signing this consent. Audubon Dental, PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the privacy officer at Audubon Dental, PC, 2960 North Circle Drive, Colorado Springs, CO 80909.
- **With my consent, Audubon Dental, PC may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.**
- **With my consent, Audubon Dental, PC may send mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.** I have the right to request the practice to restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement.
- By signing this form, I am consenting to Audubon Dental, PC's use and disclosure of my PHI to carry out TPO.
- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Audubon Dental, PC may decline to provide treatment to me.

Patient Signature:	Date:

List of Dependents:

Thank You.