Clackamas Implant & Oral Surgery Center (CIOSC)

Consent, Release and Agreement

PATIENT NAME _____ **DATE OF BIRTH** _____

(PLEASE PRINT)

NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

I acknowledge that I have been provided a Notice of Privacy Practices from CIOSC. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of bills, or in the performance of health care operations of CIOSC, as well as my individual rights and the duties of CIOSC with respect to my protected health information.

_____

Patient or Legal Representative Signature **DATE**

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS
PAYMENT IS DUE AT TIME SERVICES ARE RENDERED

I authorize payment directly to Brett M. Sullivan, DMD, MD, LLC of all benefits otherwise payable by any insurance policy(s) and I hereby irrevocably assign such benefits to Brett M. Sullivan, DMD, MD, LLC in an amount not to exceed the charges for services rendered. I agree to be financially responsible for the balance left after processing by my insurance. If not covered by insurance, I agree to be financially responsible for services rendered.

I am aware that all consults, related diagnosis, and radiographs are only guaranteed for six months.

Accepted Forms of Payment: Cash, Visa, Master Card, Discover, and Debit Cards. CARECREDIT AND LENDING CLUB are available upon approved credit.

I have read and agreed to the financial policy of CIOSC

_____

Patient or Legal Representative Signature **DATE**

CANCELLATION AND NO-SHOW POLICY

We request a minimum of 24 hours notice if you need to cancel or reschedule an appointment. Failure to provide 24 hours' notice will result in a "No-Show" on your account. After 3 no-shows, we reserve the right to discharge you from the practice. You may instead be asked to provide a deposit in an amount that is no less than $120 BEFORE you will be allowed to schedule an appointment. This deposit will be applied towards the cost of your visit. This deposit WILL NOT BE REFUNDED if you fail to keep your appointment.

_____

Patient or Legal Representative Signature **DATE**

Legal Representative Name _____

Relationship to Patient _____