Alpine Dental Care
ALPINE DENTAL CARE
19028 Stevens Creek Blvd, Cupertino, CA 95014
Email: info@alpine-dentalcare.com Tel: 408-996-8611 Fax: 408-996-8662
Web Site: www.alpine-dentalcare.com

**Patient Name:** _____

# HIPAA ACKNOWLEDGEMENT

I have read/received a copy of following documents from Alpine Dental Care:

☐ **Notice of Privacy Practices**
☐ **Comparisons of Direct Restorative Dental Material Sheet (MSDS)**

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

# INSURANCE AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Alpine Dental Care all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

# AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my dentist named above to release health information identifying me (including, if applicable, X-rays, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services).

It is completely your decision whether or not to sign this authorization for. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

***I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.***
***I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFOMRATION AS DESCRIBED IN THIS FORM.***

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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# CONSENT FOR EMAIL TRANSER OF INFORMATION

**Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to, or intercepted by unauthorized third parties. However, you may consent to receive emails from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provided.**

**Please check the boxes that best apply to you:**

- o **I consent to and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email address is:_____**
- o **I consent only to receiving appointment reminders via email. I understand I can withdraw my consent at any time. My email address is:_____.**
- o **I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.**

***I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.***
***I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFOMRATION AS DESCRIBED ABOVE.***

_____ _____
**Signature of Patient, Parent, Guardian or Personal Representative** **Date**

_____ _____
**Please print name of Patient, Parent, Guardian or Personal Representative** **Relationship to Patient**