Karina Spillman DDS, Inc.

10845 Lindbrook Drive, Ste. 204, Los Angeles, CA, 90024

CONSENT FOR TREATMENT

-I hereby authorize doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of the patient) _____'s dental needs.

-Upon such diagnosis, I authorized doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
-I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetics agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
-I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
-I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. As a courtesy we file your dental insurance claims for you. You are, however, financially responsible for all services provided to you regardless of your insurance company's coverage for a given procedure. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18%APR) may be added to my account.
-We strive to make your experience here pleasant and we do our very best to treat our patients at their reserved appointment times. If you are unable to keep your reserved appointment time, please allow us to treat another patient at that time by notifying us at least 24 hours in advance prior to your reserved appointment, otherwise a $50 charge will be incurred.

Please feel free to ask questions about our services or polices. We are committed to excellence for every patient. Our practice philosophy is based on providing all of our patients with the highest quality dental care.

Sincerely,

Karina Spillman DDS _____

Patient Signature_____Date:_____

Parent/Responsible Party's Signature_____

Relationship to Patient_____

Karina Spillman DDS, Inc.

10845 Lindbrook Drive, Ste. 204, Los Angeles, CA, 90024 (310-824-1865)

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions (except in emergency).

Patient Name: _____

Signature: _____

Date: _____

I consent to the dental practice using my cell phone number to (choose one or both) ___call or ___text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is (include area code):

___(_____)_____ _____ (patient initial)

Karina Spillman, DDS, Inc.

10845 Lindbrook Drive, Suite 204, Los Angeles, CA 90024

AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION:

Patient Name:_____ Date of Birth:_____

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing our dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling:

310-824-1865

EMAIL ADDRESS (PLEASE PRINT CLEARLY):

_____

Patient Signature:_____ Date:_____