

Jason T. Decker, DDS and Nancy A. Cavotta, DDS
Angelica P. Wong, DDS
Stephen J. Davidson, DMD (Retired)

PATIENT: _____

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY
POLICIES AND CONSENT FOR DISCLOSURE FOR TREATMENT,
PAYMENT AND OPERATIONS**

ACKNOWLEDGMENT AND CONSENT

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have, therefore, been advised of how my child's protected healthcare information may be used and disclosed by the office and how I may obtain access to and control of this information. In addition, by signing below, I hereby consent to the use and disclosure of my child's healthcare information for treatment purposes, payment activities and healthcare operations of the Capital District Pediatric Dentistry at Century Hills as described in the Notice.

Signature of the Personal Representative or Patient:

_____ Date: _____

Print Name of Personal Representative or Patient (including description of legal authority)

INSURANCE SIGNATURE ON FILE

- ___ I authorize use of this form on all my insurance submissions.
- ___ I authorize release of information to all my Insurance Companies.
- ___ I understand that I am responsible for my bill.
- ___ I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
- ___ I authorize payment directly to my doctor.
- ___ I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.