Slade W. Lail, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature: _____ Date: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please print name

_____
Signature

_____
Date

We attempted to obtain written acknowledgement of receipt or our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[ ] Individual refused to sign

[ ] Communication barriers prohibited obtaining the acknowledgement

[ ] An emergency situation prevented us from obtaining acknowledgement

[ ] Other (Please Specify)

_____
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To All Valued Patients of Dr. Slade W. Lail:

This is a letter to inform our patients of a change in office policy that will be taking effect starting January 1, 2009. Dr. Slade Lail is committed to offering the highest level of service to as many people as possible, and provides the best resources available for your appointment. Our staff works to make your experiences at our office pleasant, efficient and beneficial. If you are unable to keep your scheduled appointment, we ask that you let us know as soon as possible so we may schedule another person who needs our services into that time slot. We have always requested 24 hours notice when canceling appointments; however, when these appointments are missed, a significant amount of time is lost that could have been used to care for other patients.

Consequently, we are enforcing a **24 Hour Cancellation Fee** in the amount of $35. After 2 missed appointments, we will require pre-payment before scheduling your next appointment. Cancellations made over the weekend, via our answering machine will not be viewed as 24 hours notice. Our hours are Monday-Thursday from 7:30am - 5:00pm, so if you must cancel, please do so during our normal business hours.

We understand life's emergencies and we reserve the right to waive the fee for those who are normally punctual. We ask for your cooperation in this matter and we thank you in advance for understanding the importance of our time and schedule.

Sincerely,

Slade W. Lail, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF CANCELLATION POLICY

I, _____, have received a copy of this office's new 24-hour Cancellation Policy.

_____

Please print name

_____

Signature

_____

Date