245 E. 8th St.
Chillicothe, Ohio
(740)775-0808

To the best of my knowledge, the questions on the form I filled out have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status

HIPAA Notice of Privacy Practice

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I reviewed a copy of Wissler, Myers & Kallies Family Dentistry Notice of Privacy Practices. I am aware that I am entitled to a copy of this if I so choose.

HIPAA Release

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

Assignment of Benefits

I acknowledge that I have read a copy of the Assignment of Benefits form, and agree to all of the terms and conditions described on the form.

Release of Information

I authorize the release of any medical information necessary to process claims.

By signing below I state that I have read and understand both the HIPAA Notice of Privacy Practice HIPAA Release as well as the Assignment of Benefits and release forms. Additionally, by means of this signature, I affirm that I have filled out my Medical History as completely and accurately as possible.

Patient Name______________________________

Patient Signature___________________________
Dated_____________Relationship to Pt.___________________________

If you are signing as a personal representative of the patient, describe your relationship to the patient.