Patient Consent Form

PATIENT CONSENT FORM: FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our office providing you with quality dental care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients. Do not hesitate to discuss our policies with any member of our staff.

How our office collects, uses and discloses patient's personal information

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. Our staff are trained in the appropriate uses and protection of your information. Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

The office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care
- To identify and to ensure continuous high quality care
- To assess your health needs
- To provide health care
- To advise you of treatment options
- To establish and maintain communication with you
- To offer and provide treatment, care and services in relationship to the oral and maxillofacial complex and dental care generally
- To communicate with other treating health-care providers, including specialists and general dentists who are the referring dentists and/or peripheral dentists to allow us to maintain communication and contact with you to distribute health-care information and to book/confirm appointments
- To allow us to efficiently follow-up for treatment, care and billing
- For teaching and demonstrating purposes on an anonymous basis
- To complete and submit dental claims for third party adjudication and payment
- To comply with legal and regulatory requirements, including the delivery of patient's charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the regulated *Health Professional Professions Act*
- To comply with agreements/undertakings entered into voluntarily by the member of the Royal College of Dental Surgeons of Ontario, including the deliver/review of patient's charts and records to the college in a timely fashion for regulatory and monitoring purposes
- To permit potential purchasers, practice brokers or advisors to evaluate the dental practice
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- To deliver your charts and records to the dentist's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this office to comply with all regulatory requirements to comply generally with the law

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection , use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Your information may be accessed by regulatory authorities under the terms of the RHPA for the purposes of the RHPA for the purposes of the RCDSO, and for the defence of a legal issue. Our office will not under any conditions supply anyone with your confidential medical history. When unusual requests are received, we will contact you for the permission to release such information. We may also advise you if such a release is inappropriate. You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code, and I can ask to see code at any time.

I agree that Dr. Liu can collect, use and disclose personal information about Barry Friedman, as set out above in the information about the office's privacy policies.

Barry Friedman	Barry Friedman
Signature: Patient/Parent/Guardian	Print Name
2022-07-18	Kaitlyn Hewitt
Date	Signature of Witness

Assignment of Benefits and Cancellation Agreement

I, Barry Friedman, hereby authorize Sunset Dental Centre to submit electronic claims for myself and/or my dependents to my insurance company and agree to assign the payment directly to Sunset Dental Centre.

I understand that my insurance is an agreement between the insurance company and myself. I further understand that I am responsible for any service fees or balances that may not be covered by my dental benefits plan. I understand that I will also be responsible to submit to my secondary insurance any portion not covered by my primary insurance.

Credit Card Authorization

The insurance claim will be sent electronically on the day of your service.

You will be expected to pay the difference on the date of your appointment.

If the insurance company does not provide specific details on the coverage on the day of your treatment, your credit card will be charged the balance owing on the day the claim response is returned to us by your insurance company. A receipt will be emailed to you.

A credit card **MUST** be kept on file in order for us to provide you with an assignment of benefits. It will be your responsibility to inform us of any changes to your credit card information ie. Expiry dates. In the event the credit card is **declined a $10.00 administration fee** will be added to the account and **no further assignment of benefits will be granted**.

Please note: credit card information is securely stored in payment card industry (PCI) compliant software.

Card holder signature: Barry Friedman

Witness by: Kaitlyn Hewitt (staff member of SSDC)

Date: 2022-07-18

Cancellation Agreement

We require 48 hours notice for any change or cancellation to your dental reservation. Any cancellation within the 48 hours will be subject to a cancellation fee of $100 for any visit. We recognize the time of our clients and staff is valuable and have implemented this policy for this reason.

I have read, understood and agree to the above policies:

Barry Friedman	
Patient's name(s) (please print)	
Barry Friedman	2022-07-18
Insured Signature (Patient signature if insurer not present)	Date
Kaitlyn Hewitt	2022-07-18
Witness Signature	Date

Signature Certificate

Reference number: MRYTP-VUPQ5-8N4DG-JZ9JY

Signer	Timestamp	Signature
Barry Friedman Email: bf.mbox@pm.me		
Sent:	18 Jul 2022 15:33:15 UTC	
Viewed:	18 Jul 2022 15:44:32 UTC	
Signed:	18 Jul 2022 15:48:17 UTC	
Recipient Verification:		IP address: 142.113.120.50
✔Email verified	18 Jul 2022 15:44:32 UTC	Location: Ottawa, Canada

Document completed by all parties on:
18 Jul 2022 15:48:17 UTC