TERRY J. BILLINGS, DDS, APDC

3101 7TH STREET
METAIRIE, LOUISIANA 70002
504-832-2222 FAX 504-832-2111

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

I, _____ , hereby authorize Terry J. Billings, DDS, APDC to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, the physician can refuse to treat me.

I have been informed that Terry J. Billings, DDS, APDC has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Terry J. Billings, DDS, APDC in writing, but if I revoke my consent, such revocation will not affect any actions that Terry J. Billings, DDS, APDC took before receiving my revocation.

I understand that Terry J. Billings, DDS, APDC has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Terry J. Billings, DDS, APDC restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Terry J. Billings, DDS, APDC does not have to agree to such restrictions, but that once such restrictions are agreed to, it must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

_____ Please initial here if you would like to give us permission to speak with someone in your household regarding your care or account status. List person(s): _____

ACKNOWLEDGEMENT OF FINANCIAL POLICY

Please understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible, co-insurance or any other balance not paid by your health plan. For Medicare patients, this represents any unmet deductible and 20% of the allowed amount.

All payments are due at the time of service. All patient-due amounts must be paid within 30 days. If this creates a financial hardship for you, please contact our business office. In no case can we extend payment past four (4) months. All past-due accounts are placed with an outside agency for collection.

Checks returned for non-sufficient funds must be paid within five (5) business days from the time we notify you. Uncollected NSF checks are placed with the District Attorney's office for collection.

_____ _____

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

To Be Completed If Patient Is Unable To Sign:

_____ _____

Printed name of patient or patient's representative **Relationship to the patient**