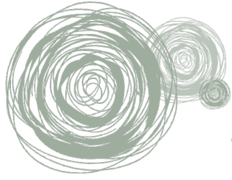


Matthew S.M. Yun
Steven R. Powell
GENERAL DENTISTRY

# *Your Privacy Is Important to Us*

**Acknowledgement of Receipt of Notice of Privacy Policies**

I have received a copy of the Notice of Privacy Practices of Song M. Yun, D.D.S., P.C.. I hereby authorize, Song M. Yun, D.D.S., P.C., as indicated by my signature below, to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

______________________________ ______________________________
Print Name

______________________________
Address

______________________________ ______________________________
Signature Date

Please check your preferred means of communication

You may contact me at my home telephone number ________________________

You may contact me on my mobile telephone number ________________________

You may text me on my mobile telephone number ________________________

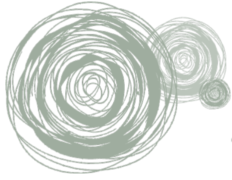
You may contact me on my work telephone number ________________________

You may send me email at: ____________________________________________

Other ________________________________________________________

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. ____________________________________ Added/Removed Date ____________
2. ____________________________________ Added/Removed Date ____________
3. ____________________________________ Added/Removed Date ____________
4. ____________________________________ Added/Removed Date ____________



Matthew S.M. Yun
Steven R. Powell
GENERAL DENTISTRY

# PATIENT CONSENT

**Clinical**

1. I authorize Song M. Yun D.D.S., P.C. and/or Steven R. Powell, D.D.S. to perform all recommended treatment.
2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payers and/or other heath professionals.
3. I authorized the use of anesthetics, sedatives, and other medication, as needed, and I am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

**Financial**

1. I am responsible for payment of all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR will be automatically tabulated into my account if my balance is greater than 30 days past due. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.
2. A $50 missed appointment fee will be charged to my account for all missed appointments or last minute cancellations by me. I am aware that to hold down operating costs, 24 hours notice of cancellation is required.

**Insurance**

1. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records and other Diagnostic Material about my medial history, services rendered, or recommended treatment.
2. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

**I have read this Patient Consent and agree to all terms and conditions herein.**

Patient's Name: ______________________________________ Date: ________________

Patient's Address: __________________________________________________________

A Dental Practice Devoted to Health
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OkemosDentistry.com