

PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION (PHI)

- I have the right to review the Notice of Privacy Practices prior to signing this consent.
  - Berman Endodontics, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Berman Endodontics Privacy Officer at 16407 Southpark Dr., Westfield, IN 46074.
- With my consent, Berman Endodontics, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Notice of Privacy Practices for a more complete description of such disclosures.
- With my consent, Berman Endodontics, LLC may call my home or other designated location, Location: \_\_\_\_\_ Phone# \_\_\_\_\_, and leave a message in voice mail or in person in reference to any items that assist the practice in carrying out TPO. These messages may include appointment reminders, insurance items and any call pertaining to my care.
- With my consent, Berman Endodontics, LLC may discuss my PHI with the following individuals:  

Name: _____	Relationship: _____
Name: _____	Relationship: _____
- With my consent, Berman Endodontics, LLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, information/instructional and patient statements.
- I have the right to request that Berman Endodontics, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my restricted restrictions, but if it does, it is bound to this agreement.
- By signing this form, I am consenting to Berman Endodontics', LLC use and disclosure of my PHI to carry out TPO.
- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Berman Endodontics, LLC may decline to provide treatment to me.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print name of Patient or Legal Guardian

OPERATORY POLICY

To comply with our liability insurance carrier, our patient treatment areas need to be considered work-restricted. In order to abide by these policies and for the safety of all parties, only patients receiving treatment are permitted in the operatory.

It is our policy that the parent/provider exchange if a dependent take place at the waiting room door. Furthermore, an individual entering the treatment area must be escorted by a staff member.

Should you have questions, please feel free to ask. Thank you for you understanding and co-operation on this safety issue.

Your signature below indicates you are aware of this policy and any questions have been answered.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date