Dr. Michaela Taskov
14 Ramblewood Drive,
Suite 201
Wasaga Beach ON
(705)429-3332
dentistryon45th@rogers.com

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.

In this office, Dr. Michaela Taskov acts as the Privacy Information Officer.

All team members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

We have provided you the opportunity to read "How our office collects, uses and discloses Patients' peronal information". This outlines what our office is doing to ensure that:

* only necessary information is collected about you;

* we only share your information with your consent:

* storage, retention and destruction of your peronal information, complies with existing legislation, and privacy protection protocols:

* our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.

Do not hesitate to discuss our policies with me or any member of our office staff. Please be assured that every team member in our office is committed to ensuring that you receive the best quality dental care.

Patient Consent

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 that Code at any time.

I agree that Dr. Michaela Taskov, can collect, use, and disclose personal information about myself/and or dependants as set out above in the information about the office's privacy policies.

Signature of Patient

Signature: _____ Date: _____

Print Patient Name/Relationship to Patient:

_____

Dr. Michaela Taskov
14 Ramblewood Drive,
Suite 201
Wasaga Beach ON
(705)429-3332
dentistryon45th@rogers.com

Financial Consent

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, and accounts exceeding 90 days will be turned over to a collection agency, unless financial arrangments are in place and are being satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I understand that I am financially responsible for any outstanding balance and that I will be billed for any outstanding account balance.

I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Print Patient Name/Relationship to Patient:

_____

Dr. Michaela Taskov
14 Ramblewood Drive,
Suite 201
Wasaga Beach ON
(705)429-3332
dentistryon45th@rogers.com

Medical Information Authorization/Consent for Services

I hereby certify that I have provided to your office my medical and dental information and it is, to the best of my knowlege, true and correct. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. If I ever have a change in my health, I will inform the office at my next dental appointment.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.

I authorize the dentist to submit insurance claims electronically, if applicable, to the insurance company on my behalf.

I consent to the performing of dental and oral surgery procedures agreed to be necessary or adviseable including the use of local anaesthetic and or relative analgesia as indicated by the dentist.

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Print Patient Name/Relationship to Patient:

_____

Response Date: _____