Welcome to Northwest Hills Smiles!
(Please Print)

Today's date:_____ DL# and State of License _____

Patient's Legal Last Name: _____ First: _____ Middle I: ____

Preferred Name:_____ Birth date:_____ Age:____ Sex: ☐M ☐F

Email address: _____

Would you like notifications by: ☐Email ☐Text ☐Both ☐Neither

Address: _____Apt _____ City: _____State: _____Zip: _____

Social Security #: _____ Preferred Ph# (_____)_____-_____☐Hm ☐Cell ☐Wk

Emergency contact name and phone #

Consent for Use and Disclosure of Health Information

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out ***treatment, payment activities, and healthcare operations only***.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, the uses and disclosures we may make of your protected health information, and other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any or your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions, at any time by contacting:

Jackie Neese Phone: (512) 345-4998 Fax: (512) 345-4966 Email: jackien@nwhsmiles.com
Address: 8500 Bluffstone Cove, Suite B-101 Austin TX 78759

You have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the contact person listed above. The revocation will *not* affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have been given an opportunity to read this office's Notice of Privacy Practices and have had full opportunity to consider its contents. I understand that by signing this Consent form, I am giving my consent to your use of my protected health information to carry out treatment, payment activities and healthcare operations only.

Signature: _____ **Date**: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name (please print): _____
Relationship to Patient: _____

YOU ARE ENTITILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.