*Mahnaz Tayarani (RDHAP)*
In-home dental hygiene services

**CONSENT FOR DENTAL HYGIENE TREATMENT**

**Patient Name**: ____________________________________________ Sex: M F

Facility Name: ____________________________________________ Date: __________

SSN: xxx-xx-________ Birth Date: _____/____/______ Room #: _______

Dental Insurance: No □ Yes □ (Please provide a copy of insurance card)

*As a courtesy to patients, the insurance claims will be filled by RDHAP, however all charges are your responsibility from the date the services are rendered.*

In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), It is required to maintain the confidentiality of your health information. These laws are complicated, but you must be provided with the following important information that are permitted or required by law. It describes how your protected health information in order to carry out treatment, payment of health care operation, and for other purposes may be used and disclosed.
Your protected health information will be used and disclosed to provide, coordinate, or manage your dental care and any related services. For example, your health/dental information may be provided to a dentist to whom you have been referred, to insure that the dentist has the information necessary to diagnose or treat you. In addition, your protected health information may be disclosed periodically to another dentist, physician, or health care provider who becomes involved in your care.
Your dental information may be used and disclosed in order to obtain payment for services rendered. Such disclosures may be made to you and insurance company, responsible party, or third party. It may be required to tell you about a treatment plan you are going to receive in order to obtain approval or to determine whether your plan will cover treatment.

*Permission granted to Registered Dental Hygienist in Alternative Practice (Mahnaz Tayarani) for reviewing the medical records and providing in-home dental hygiene services. Permission granted to take photograph for chart identification, educational purposes, and text or email to the family members.*

**Responsible Party /Power of Attorney for Health Care**:

**Name:** ________________________________________________

Phone: ______________________________ email: ____________________________________

Mailing/Billing Address: ____________________________________________________________

City/State/Zip Code: ________________________________________________________________

**Signature:**__________________________________________________ Date: ___/__/___

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