I consent to the use or disclosure of my protected health information by the staff of The Shyong Dental Group, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for the treatment rendered, or to conduct normal business operations of the Shyong Dental Group, LLC. I understand that messages may be left on my answering machine for the purpose of confirming appointment or requesting a change in appointments when I cannot be otherwise reached. I also understand that my ability to receive treatment may be conditioned upon my consent as evidenced by my signature on this document.

My protected health information means health information, including my demographic information, collected form me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This information may pertain to my past, present, or future physical or mental health or conditions and may identify me, or there is a reasonable basis to believe information may identify me.

Though every attempt is made to clarify what will and will not be covered by insurance, insurance companies are constantly changing and I understand that some procedures recommended or provided by the Shyong Dental Group, LLC may not be covered. I further understand as evidenced by my signature on this document that I am responsible for the payment of all treatment provided by the staff of the Shyong Dental Group, LLC in a timely manner whether covered by insurance or not.

_______________________________________ ___________

Signature of patient or legal guardian date

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Name of patient