PSJ ORTHODONTICS
Pitrone | Sorkin | Jarvis

Consent Form

_____ **Insurance Release**
I hereby authorize PSJ Orthodontics to release any information regarding services rendered by them and allow a photocopy of my signature to be used to file for insurance benefits.

_____ **Insurance Benefits**
I hereby authorize and direct my insurer to issue payment for services rendered to me or my dependent be made directly to PSJ Orthodontics. Regardless of my insurance benefits, I understand that I am financially responsible for the fees for services rendered.

_____ **Treatment Fee**
I understand that there is no correlation between the length of treatment, the number of office visits and the treatment fee. The fee quoted is for a treatment result regardless of the appliances used and the number of visits required to achieve the desired result. Payment plans are varied for my convenience.

Patient

Responsible Party Signature Date

EMAIL ADDRESS
(Receive office notifications, appointment reminders, and online access to your account to make payments)

Notice of Privacy Practices

(You may refuse to sign this acknowledgement)

I have reviewed the Notice of Privacy Practices.

Patient's Name (please print)

Parent/Guardian's Name (please print)

Signature and Date

For Office Use Only:

We attempted to obtain acknowledgement of the Notice of Privacy Practices but it could not be obtained because:

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented obtaining the acknowledgment
- Other (Please Specify)_____
  _____