



# Dallas Laser Dentistry

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### SECTION A: PATIENT GIVING CONSENT

#### To Enhance Your Smile:

##### **Laser Whitening**

Whiter teeth in less than an hour

##### **Veneers and Bonding**

To correct flaws and to create a more perfect smile

##### **Porcelain Bridges and Implants**

You have choices for replacing missing teeth permanently

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security #: \_\_\_\_\_

#### For Your Convenience:

##### **Hours**

Monday-Friday 8:30-4:00

##### **Credit Cards**

We accept Visa, MC, Discover, And American Express

##### **Financing**

We offer a variety of financing options

### **SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**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.

**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, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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 of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Aldo Burgos, Privacy Officer, at our office by phone, fax, mail, or email.

**Right To Revoke:** You will have the right to revoke this Consent at any time by giving us written notice or your revocation submitted to the Privacy Officer listed above. Please understand that revocation of this Consent 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 or fail to sign initially this Consent.

#### **SIGNATURE**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT**

#### About Dr. Swift:

**D.D.S., Baylor College of Dentistry**  
**Member, Academy of Laser Dentistry**  
**Member, Academy of Cosmetic Dentistry**  
**Member, American Academy of General Dentistry**  
**Member, Texas Dental Association**  
**Treasurer, Dallas County Dental Society**

#### To Reach Us:

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