NEIL HOSS, DMD

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PATIENT CONSENT, PAYMENT & INFORMATION-SHARING AUTHORIZATION

Patient name: _____ Date of birth: _____

1 | Financial Responsibility & Insurance Benefits

I authorize Dr. Neil Hoss, DMD, LLC to submit dental insurance claims on my behalf and, where permitted by my plan, to receive payment of benefits directly. I understand that my dental insurance coverage is an agreement between me and my insurer. Insurance estimates are not guarantees of payment.

I am responsible for charges not paid by insurance, including deductibles, copayments, coinsurance, excluded services, and amounts otherwise owed under applicable law and my insurance plan. Payment is due at the time of service unless the practice and I agree to other arrangements. I understand the practice may not participate with all insurance plans.

2 | Consent for Dental Services

I authorize Dr. Neil Hoss, DMD, LLC and its clinical team to perform examinations, diagnostic imaging when indicated, preventive services, and other dental care that I separately agree to after discussion. I understand that the nature, material risks, benefits, and reasonable alternatives of proposed treatment, including declining treatment, will be explained to me as appropriate. I may ask questions and may decline or withdraw consent for treatment, subject to clinical and legal limitations. This general form does not replace procedure-specific informed consent when needed.

3 | Appointment Cancellation Policy

Please provide at least 24 hours' notice when canceling or rescheduling most appointments. For extensive procedures, we request 48 hours' notice when possible. For missed appointments or late cancellations without timely communication, the practice reserves the right to assess a fee of $75 per hour of reserved appointment time, where permitted by law and applicable payer agreements. Please ask the office if you have questions about how the fee is calculated.

4 | Optional Authorization to Share Payment and Treatment Information

I authorize Dr. Neil Hoss, DMD, LLC to discuss or disclose the categories of information I select below with the person(s) I identify. This authorization is optional; refusing to sign this section will not affect my ability to receive treatment or payment processing, except where a disclosure is necessary for a requested service.

Authorized person 1: _____ Relationship: _____

Phone / contact information: _____

Authorized person 2: _____ Relationship: _____

Phone / contact information: _____

Information I authorize the practice to share (check all that apply):

☐ Billing, balances, payment arrangements, and insurance claim information

☐ Appointments, scheduling, and general office communications

☐ Dental treatment plans, proposed procedures, and cost estimates

☐ Clinical information, including diagnoses, dental records, and treatment details

Special limits or exclusions: _____

_____

5 | Duration, Revocation & Acknowledgment

This information-sharing authorization expires (choose one):

☐ On this date: _____

☐ When I am no longer a patient of the practice

I may revoke this information-sharing authorization in writing at any time by notifying the practice, except to the extent the practice has already relied on it. I understand that information disclosed to an authorized recipient may be redisclosed by that recipient and may no longer be protected by HIPAA. This authorization does not restrict disclosures otherwise permitted or required by law.

By signing below, I acknowledge that I have read and understand the financial, treatment, and appointment policies above. I also authorize information sharing only if I completed Section 4 and selected an expiration option in Section 5.

Patient / legal representative printed name: _____

Signature: _____ Date: _____

If signed by a representative, relationship / authority: _____

Witness (optional): _____ Date: _____