Scharer Dental, LLC

2620 Stewart Avenue Suite 214

Wausau, WI 54401

CONSENT TO USE OR DISCLOSE DENTAL AND MEDICAL INFORMATION

I ____, authorize **Nathan Scharer, DDS** and associates to use and disclose the dental, medical and health information for the following purposes:

- **Treatment**-includes activities performed by a dentist or dental hygienist, as well as coordinating and managing care provided to you with third parties, and consultations involving dentists, physicians and other health care providers.
- **Payment**-includes activities involved in determining whether you are eligible for dental plan coverage, billing matters and reimbursement for your dental benefit claims, as well as utilization management programs addressing review of dental services for clinical necessity, appropriateness of charges, precertification, and preauthorization of services.
- **Health Care Operations**-includes associate business and administrative affairs of this office.

You have the right to revoke this Consent. However, you must revoke this Consent in writing. Any revocation would not pertain to information already used or disclosed pursuant to this Consent during the time from within which this Consent is effective.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICES

I ____, acknowledge that I have been offered a copy of the Notice of Privacy Practices (available upon request) from the above-named practice.

BROKEN APPOINTMENTS: Should a cancellation occur with less than 24 hours notification, there is a failure to show for an appointment or you arrive excessively late and care cannot be completed as planned; we reserve the right to apply a broken appointment fee of $50.00.

PAYMENT IS DUE AT TIME OF TREATMENT: I realize that failure to keep this account current may result in my being unable to receive additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. I understand that should my personal check payment not be honorable by the financial institution, I will be charged a service fee of $25.00 and may be referred to Marathon County District Attorney's Check Enforcement Program.

I authorize and request my insurance company to pay directly the dentist or dental group insurance benefits otherwise payable to me. I understand I am financially responsible for all charges not covered by this assignment. I also understand that Scharer Dental, LLC is not responsible for denials or alternative allowances my plan may determine after services are rendered. I acknowledge and understand the policies stated above.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____ ____________

Signature of patient (parent/guardian or other person authorized by law) Date