Better Living through Dentistry - John Kong, DDS
Kew Gardens, New York

STATEMENT OF UNDERSTANDING & CONSENT FOR TREATMENT

I certify that the information I have given herein is correct and complete to the best of my knowledge. I agree that if there are any changes to my medical condition, I will inform the dental staff BEFORE any dental treatment is performed. I agree that if any adverse conditions occur as a result of my failure to provide accurate medical conditions and/or updates, I will not hold Dr. Kong and/or his associate or their staff responsible.

I agree to any examinations and x-ray radiographs Dr. Kong and/or his associate determines necessary for the diagnosis of my dental condition(s). I agree to have any local anesthetics (dental numbing injections) administered as required for my treatment, unless I have an allergy to them. I will be informed by the dental staff of any proposed treatment procedures and will be afforded the opportunity to ask questions before they are performed. Once I agree to treatment, I agree that Dr. Kong and/or Dr. Moon may use any dental materials, laboratories or techniques he deems appropriate for my treatment.

☞ Patient Signature _____ Date _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA)

SECTION A:

First Name: _____ M.I.: _____ Last Name: _____

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 our treatment, payment activities, and health care operations. **WE WILL NOT RELEASE ANY OF YOUR HEALTH INFORMATION TO MARKETORS OR SOLICITORS.**

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of out treatment, payment activities, and health care 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 is available from the Contact Person. 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 our office manager at 718-263-5991 or at the office located at 125-10 Queens Blvd. Suite 219, Kew Gardens, New York.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will NOT affect any action we took in reliance of the Onsent before we receive your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

I, _____ ___ _____ (or my personal representative), have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. I also agree that my protected health information may also be disclosed to the following person(s):_____

Signature _____ **Date** _____

☞ If this consent is signed by a personal representative on behalf of the patient, complete the followiing:
Personal Representative's Name _____ Relationship to Patient _____