Michael Masera, DDS
9660 Hillcroft, Suite 110
Houston, TX 77096
713-723-5615

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS: _____

I AUTHORIZE THE FOLLOWING T O DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION: For the purpose of billing, claims and supportive information.

Insurance Company Name _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?
Person/Family Member/Friend/Significant Other _____

Phone (_____)_____ Email _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

☐ **All health information** ☐ History/Physical Exam ☐ Past/Present Medications ☐ Lab Results
☐ Physician's Orders ☐ Patient Allergies ☐ Consultation Reports ☐ Progress Notes ☐ Diagnostic Test Reports
☐ Pathology Reports ☐ Billing Information ☐ Radiology Images ☐ Other_____

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health/dental information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

2023

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Insurance Information, Assignment and Release

As many of you know throughout the years insurance benefits have changed. The New Year started and there will probably be more changes this year. We do not always know what these changes will be until the insurance companies start processing the claims. We will do our best to help you understand your benefits, but we ask our patients to please read their insurance benefit booklet, so you can stay on top of any existing and new information.

There are hundreds of PPO insurance companies, and it is impossible to belong to all of them. We do, however, feel we are very competitive (fair) with our office fee schedule. We try to remain in the average range for our area, when it comes to fees.

There are certain guidelines that should be outlines in your benefits booklet, such as, how many cleanings and exams you may have in one year, what your deductible and maximum is and basic inclusions and exclusions. If you have been to another office and have used part of your dental maximum, this will affect the amount of benefit you have remaining to use in our office. If you have college age children, you may need to send proof of student status to your insurance company to have your child be eligible for benefits. We do our best to be as accurate as we can, but the ultimate responsibility is with the Subscriber (patient/parent) to pay whatever your insurance company does not pay in our office. If the insurance company does not pay the estimated amount to our office you will be responsible to pay the balance of your account within 30 days.

I certify that I and my dependent have insurance coverage with _____ and I am assigning the benefits directly to Dr.Masera I know I am financially responsible for any balance not paid by my insurance company for me or my dependent(s). I understand that Dr. Masera's office is giving me an estimation of the amount my insurance company will assist me (my family) with for necessary services, but I do not hold them responsible in the event that my insurance company does not reimburse the benefit as expected.

This consent is valid for one year or until December 31, 2023, for me and any dependent(s).

Signature of Patient, Guardian or Personal Representative _____

Print Name of Patient, Guardian or Personal Representative _____

Relationship to patient _____

Date _____

Witness _____ Date _____

OralID

The 2 minute exam that can SAVE your life.

Consent Form – Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID™ screening device into our office. The OralID™ examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like the OralID™ dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at Risk?

- Age - 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the OralID™ to reduce the mortality of late stage detection.

Our office fee for this procedure is $25.00 for the year.

☐ Yes, I request that your staff perform an examination with the OralID. I accept financial responsibility for this examination.

Signature Name Date

☐ No, I prefer to not have this examination at this visit.

Signature Name Date