Dr. Zenon Farian
One Time Authorization Form

Patient Name _____

MEDICAL CONSENT: I require evaluation and/or treatment by a dentist and hereby consent to and ask for such care. This includes routine diagnostic work, and dental treatment that my dentist considers necessary. I acknowledge that no guarantees have been made to me regarding the outcome of examinations or treatment. I am aware of the potential risk of COVID-19 as soon as I enter the office and consent to dental treatment by Dr. Farian and his team. I understand that I will not be involved in any research or experimental procedure without my knowledge or consent.

ASSUMPTION OF RESPONSIBILITY: I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to Zenon Farian, D.D.S., all charges for such services and incidentals incurred. Even though my insurance may be filed, I understand that all copays and deductibles are due at the time of service and any bills are payable upon receipt. I also understand that I and not the insurance company, am responsible for the payment of all services. In the event that an outside source for collection of fees becomes necessary, I will be responsible for all collection fees incurred, as well as interest and late fees. If cancellation of an appointment is required, I agree to a 48 hour notice, or a short notice cancellation fee may be assessed.

PERMISSION FOR DISCLOSURE: I give my permission to disclose my protected health information to the following people (list names and relationship):

Name _____ Relationship _____

ASSIGNMENT OF INSURANCE: I hereby assign direct payment of any dental insurance benefits, or injury benefits payable because of liability of a third party or organization, to Zenon Farian, D.D.S. for the above said patient until account is paid in full.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I acknowledge receiving today a copy of Zenon Farian, D.D.S.'s notice of privacy policies. I consent to the use of protected health information as described in the notice for treatment, payment, or health care operations. I have read and understand my HIPPA rights.

_____ _____

Signature of Patient or Patient's Representative Date